DOCUMENT RESUME

ED 364 036 EC 302 606

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TITLE	Student Assistance Programs and High Risk Youth.
INSTITUTION	Northwest Suburban Special Education Organization, Palatine, IL.
SPONS AGENCY	Department of Education, Washington, DC.
PUB DATE	92
NOTE	223p.; A product of the Comprehensive Special Education Drug Initiative.
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF01/PC09 Plus Postage.
DESCRIPTORS	Communication Skills; Coping; *Disabilities; Drug Abuse; Elementary Secondary Education; *High Risk Students; *Intervention; *Prevention; Program Development; Risk; Self Esteem; *Student Behavior; *Substance Abuse; Teamwork
IDENTIFIERS	12 Step Programs

ABSTRACT

This manual discusses a method for developing a comprehensive drug abuse prevention and intervention program for students in special education. The first section contains introductory material regarding high risk students in general and implications for special education. The second section outlines material on specific types of high-risk students, including use of alcohol and other drugs, smoking, depression and suicide, and gang involvement. The third section looks at children who grow up in dysfunctional families and the impact of this on a child's ability to function in school. In the fourth section, the concepts of "enabling" (allowing youth to continue high-risk behavior) and "empowering" (deterring high risk behavior) are discussed. The fifth section includes the "nuts and bolts" of a comprehensive program to address the needs of high-risk youth and to prevent other youth from getting involved in high risk behavior. The concept of a "core team" to implement this program is covered. Section six covers effective communication skills and research on helping children survive trauma in their lives. Ways that school can help build in protective factors which facilitate this survival (most specifically self-esteem) are discussed. Finally, information about 12-step programs of recovery (such as Alcoholics Anonymous) is presented. (References accompany each chapter.) (JDD)

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Comprehensive Special Education Drug Initiative

Student Assistance Programs
And
High Risk Youth

EC 302606

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Student Assistance Programs
And
High Risk Youth

by

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THE BRIDGE BUILDER

An old man, going a lone highway,
Came at the evening, cold and gray,
To a chasm, vast and deep and wide,
Through which was flowing a sullen tide.
The old man crossed in the twilight dim
That sullen stream had no fears for him;
But he turned, when he reached the other side,
And built a bridge to span the tide.

"Old man," said a fellow pilgrim near,
"You are wasting strength in building here.
Your journey will end with the ending day;
You never again must pass this way.
You have crossed the chasm, deep and wide,
Why build you the bridge at the eventide?"

The builder lifted his old grey head.
"Good friend, in the path I have come," he said,
"There followeth after me today
A youth whose feet must pass this way
This chasm that has been naught to me
To that fair-haired youth may a pitfall be.
He, too, must cross in the twilight dim;
Good friend, I am building the bridge for him."

Will Allen Dromgoole

INTRODUCTION

As educators, all of you are "bridge builders" who bring to your classroom a variety of skills and experiences which allow you to reach out to your students. As special educators, you deal with a population of students who are, perhaps, the most "at-risk" of all student populations. These are young people who suffer from low self-esteem; who are experiencing difficulty or even failure in school; who feel "different" from other students and are constantly searching for ways to fit in; and whose coping skills are seriously lacking. Individually there are many things you can do to make a difference in these students' lives. Collectively, as a team, that ability to make a difference is magnified.

The national effort to ensure drug-free schools has, over the years, produced a wide array of school-based prevention/education and intervention efforts. Prevention programs have ranged from those which focus on drug information and the dangers of drug use to those stressing affective techniques and skill building. Intervention models have usually involved the two extremes of suspension and expulsion or overlooking the natural consequences of the behavior and sending the child to treatment. Although each method has some strengths, none of them have been effective in isolation.

Current research into substance abuse prevention and intervention indicates the need to move toward a program that is more comprehensive in nature and that promotes general wellness rather than being known as a "drug program". According to the Prevention Resource Center in Springfield, IL, "efforts focused on a single system and single strategy will probably fail". To be effective, programs must "target multiple systems (youth, families, schools, workplaces, community organizations, and media) and use multiple strategies (provide accurate information, develop life skills, create positive alternatives, train impactors, and change community policies and norms)".

Throughout this manual, a method for developing a comprehensive prevention and intervention program will be discussed. Although the responsibility for responding to the needs of high-risk students does not rest solely on the shoulders of school personnel, school is an ideal place to address many of these issues. Within the school setting are trained adults who each see the child from a slightly different perspective and often notice problem behavior before it becomes evident in the home or community. Students also spend a large percentage of their day in school which makes it an excellent place for on-going programs of support and skill building. Finally, the task of the school is to educate students and prepare them to move successfully into their chosen career path. When issues such as substance abuse, suicide or living in a dysfunctional family occur in a child's life, it often interferes with the educational process. It then becomes necessary for school personnel to assist in resolving these issues so that the learning process can be facilitated. This does not mean that educators will become therapists. It does mean that schools need to establish programs to address more than the 3 R's.

This manual is divided into several sections to help organize the material into a useful model. The first section contains introductory material regarding high risk students in general and specific issues for special education regarding substance abuse. The second section outlines material on specific types of high-risk students including: use of alcohol and other drugs; smoking; depression and suicide; and gang involvement. The third section looks at children who grow up in families where there is some type of dysfunction (chemical dependency, abuse, mental illness, etc.) and how that can impact on a child's ability to function in school. In the fourth section the concepts of "enabling" (how we can allow kids to continue high-risk behavior) and "empowering" (how we can deter high-risk behavior) are discussed. The fifth section includes all of the "nuts and bolts" of a comprehensive program to address the needs of high-risk kids and to prevent other children from getting involved in high-risk behavior. The concept of a "Core Team" to implement this program is also covered. Section six covers two very important topics in prevention and intervention: communication and resiliency. Effective communication skills are examined along with the latest research about helping children survive trauma in their lives (resiliency). Ways that schools can help build in protective factors which facilitate this survival (most specifically self-esteem) are discussed. Finally, under the miscellaneous section is information about 12-Step Programs of recovery (such as AA, NA, Alanon, etc.). Since many students who go through a treatment program for addiction will be involved in these, it is important for school personnel to understand their principles.

There are no magic answers in this manual. Unfortunately, in dealing with high-risk kids, there are also no easy answers. There are, however, tactics that have been proven effective in helping students who have gotten involved in dysfunctional behavior to change and in helping other students who are at risk for these behaviors to chose more healthy coping skills. We hope that this material will be useful and will make your job ultimately easier and the lives of your students more successful.

KIDS OF THE 90'S

> Just when I was getting used to yesterday....
> Along came today.
> -Ashleigh Brilliant-

The world of the 1990's is very different from the world of even 15-20 years ago. Some of the changes that have occurred have been positive, others have been negative. All of them have had the effect of putting kids more at risk for dysfunctional behavior such as substance abuse, sexual promiscuity, delinquency, and suicide. The primary factor in this risk is the existence of stress created by the changes in kids' world.

Stress is a difficult concept to define. The dictionary definition is vague and general, stating that it is "a factor that induces bodily or mental tension and may be a factor in disease causation". What this seems to indicate is that what is crucial is not the specific factor, but the person's response to the factor. Therefore, anything can be a stressor. Generally we view stress as a reaction to some form of change or crisis that goes beyond what is considered normal. Many different stress inventories have been developed, all of which focus on change or crisis in a person's life (some positive, some negative). Ultimately, as stress increases so does a person's risk potential. And as the person's risk increases, their stress level also increases creating a vicious circle.

Adolescence is a time of change and stress under the best of circumstances. Their bodies are growing and changing rapidly, particularly with respect to hormonal and sexual development. This causes severe mood swings and insecurity as each adolescent tries to measure their body next to their peers. These kids are also beginning to make the break out of the relative safety of childhood into adulthood. This means separating from family, making career choices, learning to be responsible, and identifying their own life values.

Childhood is only slightly less volatile. The hormonal/physical changes and drive toward independence may not be present (or at least not to the same extent) but there is rapid change nonetheless. And if we consider stress as being change that is outside of what is familiar, then due to their lack of experience any change is stressful.

The changes that we see in the world of today can be found in many areas, all of which impact the individual. Family structure, schools, communities, institutions, media, and technology have all changed dramatically. The U.S. Department of Labor has estimated that with the present rate of technological change, workers must be retrained every 18 months in order to keep up with advances. Although this represents a positive change in many ways, is it any wonder that students find it hard to get excited about learning material that may be outdated by the time they get a chance to use it?

Family structure has also changed dramatically. H. Stephen Glenn has spent a lot of time studying children and their families. He has found a major transition occurring in lifestyles, all of which impacts kids and their risk potential. Some of the changes he has identified include:

Norm 1930	**Norm 1980**
* High family interaction 2-4 hours per day	* Low family interaction 12½ minutes per day
* No television	* Average 7 hrs TV per day
* Logical consequences	* Logical consequences avoided
* Many intergenerational relations	* Few intergenerational relations

* Less education	* More education
* Low level of information	* High level of information
* Low technology	* High technology
* Many non-negotiables	* Few non-negotiables
* Much family work	* Little family work
* Larger families	* Smaller families
* Extended family dominant	* Nuclear family dominant
* Few broken homes (10-15%)	* Many broken homes (38-42%)
* Little anonymity	* General anonymity

One of the major problems in addressing this change in family structure is that most of our social institutions are based on the family of the 1930's - 1950's. William White of the Lighthouse Training Institute refers to "pathology enhancing cultures" which increase the likelihood that kids will get involved in gangs, drug use, or cults. One of the primary themes he discusses is that of isolation and disconnectedness. As families become smaller, more mobile, and more nuclear, there is an increase in this isolation and a corresponding increase in high risk kids.

Schools have also seen some dramatic changes. According to the California Department of Education, in the 1940's the top discipline problems faced by educators (in order of severity) were talking, chewing gum, making noise, running in the halls, getting out of line, improper clothing, and not putting paper in the wastebasket. Although these problems still exist in the classroom of the 90's, the top seven discipline issues are now listed as drug abuse, alcohol abuse, pregnancy, suicide, rape, robbery, and assault. Is it any wonder that educators feel so frustrated and fewer young people view teaching as a desirable career choice.

All of this leads to some very frightening predictions about the future for the kids of the 90's. Dr. Elizabeth Anderson of the University of Kansas School of Medicine has predicted that before the high school class of 1994 graduates, each student has the following chances for high risk behavior:

- 40% chance he/she will be a partner in pregnancy.
- 75-80% chance that he/she will have a car accident.
- 86% chance that the first 6-9 months of sexual intercourse will be unprotected by any form, including a condom.
- 90% chance that he/she will experiment with alcohol.
- 65% chance that he/she will use alcohol regularly.
- 50% chance that he/she will experiment with marijuana.
- 23% chance that he/she will experiment with stimulants.
- 17% chance that he/she will experiment with cocaine.
- .045% chance that he/she will get AIDS.

As a result, it is no longer possible for any one person or institution to take on the responsibility of addressing these issues. It will take the combined efforts of families, schools, law enforcement, churches, community groups, etc. to reduce these statistics and increase the chances of producing a healthy generation of kids. Much of what is necessary for that will be discussed in the section on Resiliency and Self-Esteem.

In addition to a focus on change and stress as a factor in increasing risk potential, a number of other risk factors have been identified by researchers. Some of these will be discussed more specifically under the section on Chemical Dependency as they tend to be correlated to substance use and abuse. Others are more generic and can lead to any number of dysfunctional behaviors including substance use, gang involvement, eating disorders, depression, and suicide. The risk factors fall into several major categories such as family-centered, school-centered and personality characteristics.

Success or failure in school appears to have a major influence on a child's risk potential. Many of the risk factors in the school-centered as well as personality characteristics are found routinely in the special education population. These include:

- being a year or more behind in math or reading
- a history of absence, truancy and tardies
- poor language skills
- poor social skills
- early failure to succeed in school
- repeated discipline problems
- lack of positive identification with school
- being socially immature
- having low self-esteem
- having poor planning skills
- being hostile, unruly, aggressive, or passive-aggressive
- being apathetic, bored, unwilling to try, and dis-interested

Most educators in a special education setting will look at this list and recognize many (if not all) of their students. This does not mean that every special ed child will become a drug addict. What it does mean is that these kids have a higher risk for all types of dysfunctional behaviors than other kids who experience more success in school.

High Risk Kids:

We have discussed the issue of change in our world increasing the risk potential for young people. But to understand exactly how and why that happens it is important to define the concept of high risk kids. We need to actually look at two levels of "riskness" and what creates each. To define these, we will use two formulas:

Developmental Issues + Situational Stress = At Risk

At Risk + Low Self-Esteem + Lack of Coping Skills & Support = High Risk

Children who are "at risk" can be visualized as standing at a crossroads. They can choose healthy responses and behaviors or dysfunctional behaviors such as substance abuse and delinquency. Children who are "high risk" have generally chosen to take the road leading to dysfunctional behaviors or are much more likely to do so.

The "at risk" formula refers to developmental issues and situational stress. Developmental tasks are those things that need to be accomplished at each life stage such as developing responsibility, learning social interaction skills, becoming independent, adjusting to a changing physical self (hormones and growth spurt), and making career choices. One of the primary tasks of adolescence involves peer interaction. Most special education students feel very different and are desperately looking for ways to fit in with the mainstream. For many, the use of alcohol and other drugs becomes an easy way to be accepted since that peer group asks only that member's engage in the use of chemicals and protect that use from discovery.

Situational stress refers to the things that happen, good or bad, that create change in the child's life and/or create stress for a defined length of time. For special education students, particularly the learning disabled, school is a highly stressful environment. Things don't come easily, and for some the use of chemicals becomes a way of dealing with that stress. Using this formula and the definitions, it is safe to state that all children are "at risk" at some point in their life. So what causes some kids to choose healthy behaviors and some dysfunctional ones?

This question is answered in the "high risk" formula. Here we add in low self-esteem and a lack of coping skills and support. Self-esteem as a concept has had many definitions, but essentially it is the term used to describe "self-evaluative behaviors, attitudes, beliefs, or perceptions". (Hayes and Fors, 1990) When asked how many of their students experience low self-esteem, a group of special education teachers working with a learning disabled population here in the Northwest Suburbs of Chicago stated that it was close to 95%. People working with a behavior/emotional disordered population state that although their students attempt to show the world how "cool" they are, their self-esteem is extremely low and this leads to much of their acting out behavior. As stated earlier, these are children who feel different and who experience difficulty learning in school. Many have been told that they are "stupid", "no good", and will "never amount to anything", and they begin to believe this is true. When they are intoxicated they can leave this self-image behind and be whoever they want to be, including "cool". It is also typical for a child who does not feel worthwhile to have a hard time choosing healthy responses and behaviors. This is one of the key problems with prevention programs that focus on refusal skills without addressing feelings and self-esteem.

The second piece of the "high risk" formula involves coping skills and a healthy support system. The coping skills that are needed in order to be able to avoid dysfunctional behaviors include decision making, stress management, communication, and refusal skills. These are the skills which will allow the student to choose healthy behaviors once they feel they are worthwhile. However, in order to learn these skills, one must have a supportive system in which to try these new behaviors. Therefore, it is also important for the child to have a healthy support system to turn to in times of stress and confusion. Research with high risk youth has indicated that those children who have a healthy, supportive relationship with a parent or other adult are better equipped to deal with trauma in their lives in a positive way. (Garmezy, 1974; Rutter, 1979; Werner, 1982) According to the same group of teachers questioned about self-esteem, the majority of their students have very poor social skills and, therefore, have little in the way of a support system. In the case of the behavioral/ emotional disordered students, they tend to develop a support system which feeds into each other's dysfunctional, problematic behavior. In addition, most special education students have not learned the coping skills listed above and are, therefore, at much higher risk for problem behavior. If we consider this second formula and the reports of special education teachers, the conclusion that can be drawn is that almost all special education students are high risk. The key, then becomes making sure that programs are in place in the schools to meet their needs, which is the goal of Student Assistance Programs.

What Can Be Done?

After reviewing the changes in society, defining high risk students, and as we proceed throughout the week discussing the various types of dysfunctional behavior it is very easy to feel depressed, frustrated, and overwhelmed. The typical response is to exclaim, "I'm only one person, how can I possibly make a difference." But as you say that, keep in mind the following story.

A man was walking along the beach at sunrise. As he walked, he noticed that the tide was going out leaving many starfish stranded on the beach. He knew that as the sun rose and the day got hotter that many of the starfish would die. As there were so many of them and only one of him he couldn't see any way to change that fate. So he walked on, trying not to notice. Up ahead on the beach he noticed a small figure walking along toward him. Every so often the figure would stop, bend down, and throw something in the water before continuing. As the man neared the figure he noticed that it was a young boy who was bending down, picking up starfish and throwing them in the water. Some of those starfish stayed in the water and others were washed back up on the beach. The man watched the boy and then questioned him: "Why are you bothering to throw the starfish back in? There are so many of them, you can't possibly make a difference." The boy thought for a minute then bent down to pick up a starfish and threw it into the water. As he watched it sink below the waves he turned to the man and replied: "I made a difference to that one."

IMPLICATIONS FOR SPECIAL EDUCATION

Since the inception of P.L. 94-142, school districts have been mandated to consider the needs of disabled students. This has lead to the development of some very effective programs for students with learning disabilities, emotional/behavioral disorders, mental deficiencies, and physical handicaps. As we begin the 1990's and look toward the year 2000, the task that is before educators in general, and special educators in particular, is to prepare students to meet the demands of society as healthy, productive citizens. For each child this will mean something slightly different as we consider their special talents and special needs. Overall, it means helping students to develop healthy coping skills, supportive relationships with caring adults, and positive self-esteem. It means helping them to avoid such high risk behaviors as alcohol and other drug abuse, depression and suicide, delinquency, teenage pregnancy, and eating disorders.

In considering the risk factors for dysfunctional behaviors, special education students, by nature of their disability, are at risk. As was discussed, they suffer from low self-esteem and often do not possess effective social skills. They are likely to experience failure in school, an inability to develop or maintain healthy relationships with peers or with adults, an inability to recognize and respond to feelings, and a persistent feeling of unhappiness or depression. All of these factors make them more likely to engage in high risk behaviors as a way to fit in, cover up feelings, or temporarily deal with stress.

Although many substance abuse prevention/education programs in the school setting have addressed the issues of self-esteem and coping skills, special education students have not been adequately served. If we take into consideration the fact that the special education population is a very high risk one, it would stand to reason that specific programs would be developed to meet their needs. This has not been the case. Only one curriculum has been developed nationally for the special education student (Project Oz - A Special Message) and it is only used sporadically. It also addresses only grades 6-12 at this point and most research indicates that prevention needs to start much earlier. Although individual special education teachers and programs have been adapting programs to meet the needs of their students, a more comprehensive process needs to be developed. Materials need to be adapted to the reading levels of special education students without lowering the level of maturity and interest. Skill building processes, such as decision making and refusal skills, need to be included in the educational process along with more traditional topics. Activities to foster self-esteem need to be integrated into the classroom setting. Communication/relationship skills need to be modeled and taught by special education staff. All of this needs to be implemented utilizing as many different learning styles as possible. Integrating movement, art, music, and role playing along with the more common auditory learning is crucial when dealing with the special education population. By doing this, we can begin to reduce some of the risk factors and promote success in these special students.

The C.S.E.D.I. Project and the Student Assistance Teams that will be established is designed to start addressing these issues within NSSEO Programs and Member District Schools. Pilot programs are being identified to begin training teams (see the next section on Student Assistance Programs) and implementing curricula. The end result will be a model that other schools can adopt. One which will mean that special education students in the Northwest Suburban Region will have a better chance of success as they move out into the world.

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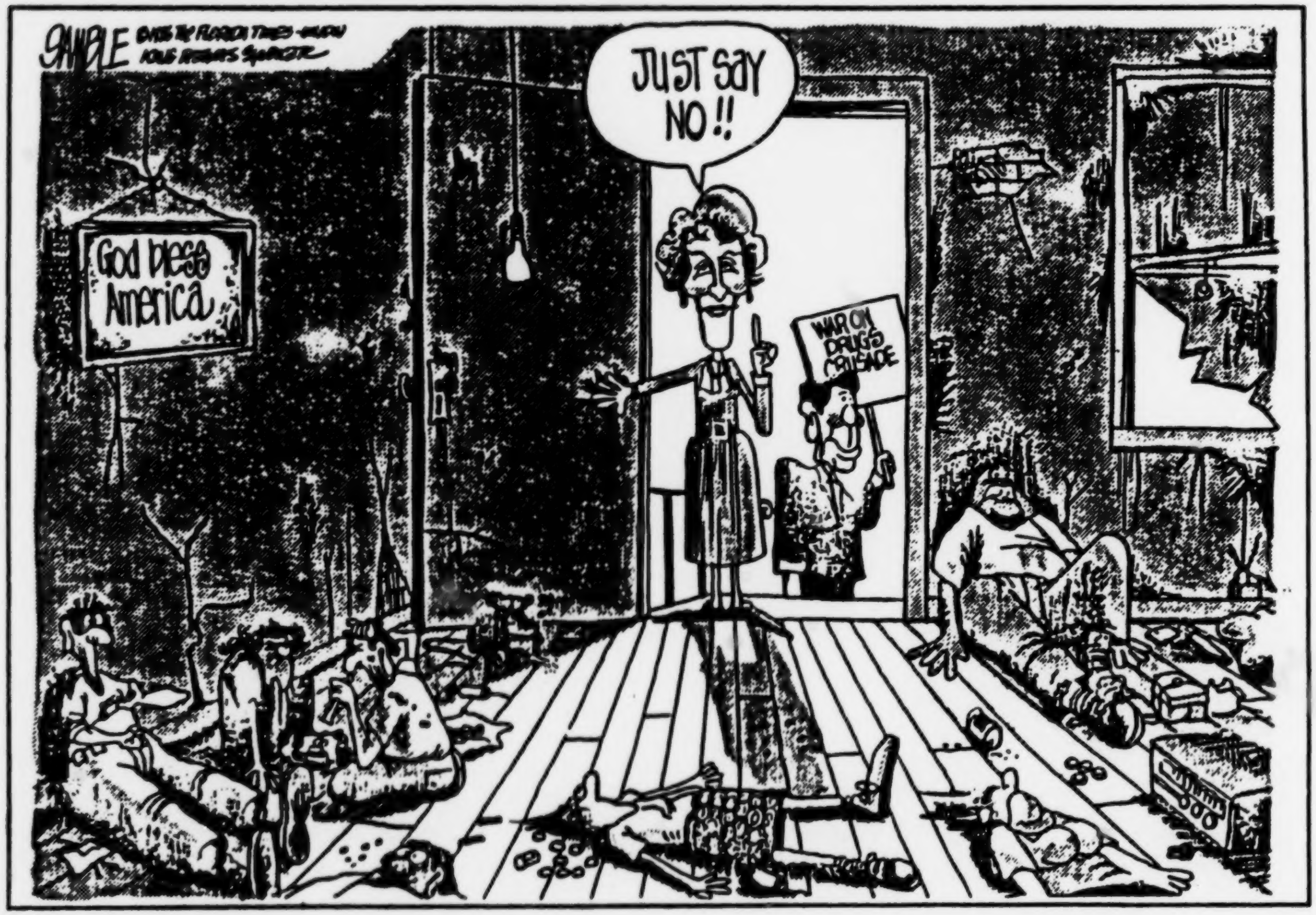

GAMBLE
JUST SAY NO!!
God bless America
WAR ON DRUGS CRUSADE

ADOLESCENT SUBSTANCE ABUSE

> Somehow I reached excess without even
> noticing when I was passing through
> satisfaction.
> -Ashleigh Brilliant-

One of the most widely spread types of high risk behavior is adolescent substance abuse. Many of these young people begin drinking by age 12, smoking marijuana by age 13, and using other drugs by age 14. Other specific statistics from the National Institute on Alcoholism and Alcohol Abuse (NIAAP), the National Institute on Drug Abuse (NIDA) and the University of Michigan Social Science Research Institute include:

- 92% of all high school seniors have tried alcohol at least once.
- 50% of high school seniors have tried marijuana.
- 26% of eighth graders and 38% of tenth graders report having had five or more drinks during the two weeks prior to being surveyed.
- 21% of high school seniors have smoked marijuana in the last 30 days.
- 10% of high school seniors drink alcohol on a daily basis.
- 100,000 deaths each year are attributed to alcohol.
- Alcohol is the leading cause of death in the 18 - 25 year range.
- Kids see 400,000 TV commercials between birth and 18 years of age that provide a "DO DRUGS" message.

- * The United States has a $60 billion drug business that costs us $117 billion in health care, lost productivity and work related injury.

The charts on pages 43-45 give specific data on national drug use by high school seniors from 1975 - 1987.

In order to begin addressing these issues, we must first identify some of the risk factors for young people, many of which can be identified in the early grades, thus providing the opportunity for early intervention. Dr. J. David Hawkins and Dr. Richard F. Catalano (1986) of the Social Development Research group at the University of Washington have developed a list of risk factors for adolescent substance abuse. These risk factors are very similar to the ones developed for heart disease or lung cancer. The presence of one or more of these characteristics should be seen as an indication that the child is more likely to develop an alcohol or drug problem, but is not an absolute guarantee. The more factors present, the higher the risk. It is also true that some of these risk factors have been found to predispose a child to other high risk behaviors such as suicide, eating disorders, or delinquency. Therefore, they should all be seen as early warning signs and an indication of the need for prevention and early intervention. They are listed in the most probable order of occurrence, not in order of importance.

1. **Family History of Alcoholism or Addiction:** Much of the available research indicates a strong link between family drinking problems and adolescent substance abuse. This predisposition may be genetic, environmental, or a combination of both, but the fact remains that there is a strong correlation. The presence of an addicted family member (particularly the same sex parent) leads to a 50%

greater chance for addiction. A child with two addicted parents has an 80% greater chance of developing a problem with chemicals.

2. **Parental Drug Use and Positive Attitudes Toward Use:** A parent's attitudes and behavior with respect to alcohol and other drugs-just like their attitudes and behaviors with respect to other issues, like religion or politics - influence those of the child. Parental use of alcohol or other drugs (even if it is in a social manner) increases the risk that children will initiate the use of drugs. Parental involvement of the child in their use (asking a child to get a beer from the refrigerator, light their cigarette, or mix their drink) also increases the likelihood of the child's use. Interestingly, a parent's attitudes about alcohol use seems to influence the child's attitudes about other drugs. Children in the 9th grade whose parents approved of their drinking under parental supervision were more likely to have used marijuana and to be using marijuana than children whose parents disapproved of drinking at home, supervised or not. What this indicates is that parents who believe that allowing a child to experiment with alcohol at home "because they will do it anyway", are (unknowingly) doing more harm than good.
3. **Family History of Criminality or Antisocial Behavior:** A family history of criminality increases a child's risk for alcohol or other drug problems. There also seem to be a relationship between substance abuse in adolescents and parental behaviors such as child abuse or neglect, and inappropriate expressions of anger.
4. **Family Management Problems:** In order to be able to make good decisions about their behavior, children need to have clear and consistent guidelines for appropriate and inappropriate behavior.

Families who have difficulty setting these limits in healthy ways have been linked in many cases to adolescent alcohol and other drug abuse. The specific problems identified have included poorly defined rules for behavior, inconsistent discipline, inadequate parental monitoring of children's behavior, constant criticism, excessively severe consequences, and overinvolvement by one parent coupled with distance by the other parent.

5. **Early Behavior Problems:** A consistent relationship has been found between conduct disorders in elementary school and later drug abuse. This risk factor is especially significant when it is aggressiveness combined with shyness or withdrawal in young boys. Other behaviors include hyperactivity, nervousness, inattentiveness, impulsiveness, and behaving in defiant and negative ways. One caution is that evidence suggests that the presence of these behaviors prior to elementary school is not predictive of drug abuse as these may be normal developmental behaviors for preschool children.

6. **Academic Failure:** Children who do poorly in school (low or failing grades), particularly in the 4th, 5th and 6th grades, have a much higher incidence of drug abuse than other children. Poor school performance appears to be linked to earlier onset of use and greater potential for abuse.

7. **Little Commitment to School:** Students who are not committed to educational pursuits are more likely to engage in early and heavy drug use. Use of strong drugs (cocaine, stimulants, or hallucinogens) is significantly lower among students who expect to attend college.

8. **Alienation, Rebelliousness, and Lack of Social Bonding:** Some children see themselves as standing apart from the rest of their peers. They adopt an "I don't care" attitude about school, home, and other social institutions. Those students (particularly in middle or junior high school) who do not adhere to the dominant values of society, who rebel against authority (such as parents and school officials), and who have weak religious affiliations, tend to be at higher risk for drug abuse than those who are bonded to family, school, and church.
9. **Antisocial Behavior in Early Adolescence:** The behaviors included here tend to be misbehaving in school, skipping classes or school, and getting into fights with other children. Research has shown that nonconformity to traditional values, high tolerance of bizarre behavior, resistance to traditional authority, low social responsibility, low social skills, and sensation seeking are all closely related to alcohol and other drug abuse.
10. **Friends Who Use Drugs:** This is a very strong predictor of adolescent drug abuse and functions independently of the other risk factors. Therefore, even children who do not have the other risk factors but associate with children who use drugs are at risk for developing substance use problems. Initiation into alcohol and other drug use occurs most often through peer pressure because teenagers are highly susceptible to being influenced by their friends.
11. **Early First Use of Drugs:** Children who will later develop problems with their alcohol or other drug use tend to begin using at an early age. This early initiation increases the

> risk of heavy use and is associated with use of "harder" drugs. Onset of alcohol or other drug use prior to age 15 is an especially strong predictor of later problems. Postponing the age of initiation of use until age 19 or beyond lowers the risk considerably.

Again, the more risk factors present, the greater the potential for the child to exhibit high risk behavior in adolescence. Special education students experience, in general, a high percentage of these risk factors - particularly the school and behavioral ones. This further supports the implications and recommendations discussed in the last section.

There are two other risk factors that should be noted here that were not listed by Hawkins and Catalano. The first is cigarette smoking. There is an extremely high correlation between abusive use of alcohol and use of nicotine. This is not to say that all people who smoke cigarettes abuse alcohol. The correlation is that the majority of alcoholics and other drug addicts (with the possible exception of cocaine addicts) smoke heavily. With regard to adolescent use, Dr. Robert DuPont (1984) indicates that 12 to 17 year olds who smoke are twice as likely to be currently using alcohol than those of the same age who do not smoke. In addition, those young people who use cigarettes are ten times more likely to use marijuana and 14 times more likely to use cocaine, hallucinogens or heroin. His conclusion, therefore, is that prevention of cigarette smoking should be a high priority in the prevention of substance abuse among young people.

The second factor is one that is of specific interest to special education. In 1987, the Santa Clara County of Education, Santa Clara, CA, published a list of risk factors. Included in that list were "disabling conditions". Although there is little specific research to date regarding handicapping conditions and high risk youths, there were several correlations mentioned. First, in examining records of child abuse cases, it was found that due to an inability to accept or cope with handicapping conditions, children with disabilities were more likely to be physically or emotionally abused. Secondly, learning disabilities have been linked to frustrations, acting-out, low self-esteem, and school failure. Many juvenile judges reported that a majority of the young people referred to court had undiagnosed learning disabilities. Finally, the existence of an emotional disorder has been linked to many of the previously mentioned risk factors including poor educational performance, alienation and rebelliousness, antisocial behavior, and family management problems. All of this again points out the importance of establishing effective prevention programs within special education populations.

STAGES OF ADOLESCENT DRUG USE

Adolescents cannot be fit neatly into two categories, users and non-users. Instead, we need to look at this use based on a continuum.

No Use	**Experimental Use**	**Regular Use**	**Dysfunctional Use**	**Chemical Dependency**

1. **No Use**

    * students who choose not to use

    * includes "not yet" users

- don't use for a variety of reasons (family, religious, cultural)
- older adolescents who are still in this catagory tend to be able to resist peer pressure and "do their own thing"

2. **Experimental Use**
   - use is usually spontaneous and unplanned
   - usually use with peers
   - based on curiosity or a desire to "fit in"
   - happens once or twice at most, then makes a choice
3. **Regular Use**
   - goal is to get "high"
   - use with friends on a regular basis
   - conscious choice to make drugs a part of their life
   - no significant consequences
4. **Dysfunctional Use**
   - beginning to experience negative consequences from use
   - develop a new value system which legitimizes use
   - become preoccupied with use
   - make lifestyle changes to accommodate use
5. **Chemical Dependency**
   - compulsion to use regardless of risk
   - preoccupation with use
   - may be using to avoid withdrawal
   - use to feel normal

The majority of adolescents move through the first three stages of use and go no further. The primary characteristic of these stages is that the individual can, and does, make a choice about whether or not to use. Approximately 15 - 20% of adolescents cross an invisible line into dysfunctional use or chemical dependency both of which are characterized by a lack of choice. For these young people, using has become so "normal" and habitual (and in many cases necessary to avoid the pain of withdrawal) that the only "choice" comes in deciding how to use so they don't get caught.

By discussing the stages of adolescent drug use, the intention is not to advocate or even validate this use, merely to acknowledge it. Many people, both in the education and substance abuse fields, adhere to the statement by former First Lady Nancy Reagan that with respect to adolescent drug use, "all use is abuse". This is because of the fact that the adolescent is going through many emotional, physical and social changes at this particular stage of life. Any use of mood altering chemicals can seriously effect these developmental tasks to the point where they must be dealt with later in life (as in emotion and social development) or may be permanently damaged (as in physical development). It has also been shown that adolescents progress much more quickly than adults through the stages of use, often going from first use to chemical dependency in as little as 6 - 18 months. For this reason, it is important that the goal of prevention be to delay the onset of substance use as long as possible.

CHEMICAL DEPENDENCY

Chemical dependency is the term used to describe addiction to any mood altering chemical. It replaces the more specific terms of "alcoholism" and "drug addiction". The reason for this new term is two-fold. First, there are fewer and fewer "pure" alcoholics or drug addicts. Most people who are addicted to mood altering chemicals tend to use a variety of them. Second, the use of two terms provided validation for the mistaken notion that alcohol is not a drug. People could say "I'm not a drug addict. I only drink alcohol". Alcohol is as much a drug as marijuana, cocaine or heroin.

Nicotine is also a drug and is one of the most addicting drugs known. A section on nicotine addiction is included for that reason. Typically, nicotine is not included in discussions on chemical dependency because its consequences tend to differ somewhat (people do not tend to be arrested for smoking or experience behavioral changes while using cigarettes). Its use has also historically been more socially acceptable (although this is changing) and many professionals in the field of addiction were themselves smokers so were reluctant to look at nicotine in the same light as other drugs. However, its use does fit under the term "chemical dependency" and should be addressed by school substance abuse programs. Also, as was discussed earlier, there is a high correlation between use of the drug nicotine and other mood altering chemicals.

There have been many definitions for chemical dependency ranging from the very simple to the very complex. The one that will be used throughout this manual is as follows:

> Chemical dependency is a condition in which the use of **any** mood altering chemical is associated with problems in **any** area of life **and** the use continues (or increases) in spite of the problems.

Based on this definition, it does not matter what a person uses (alcohol, pot, cocaine, nicotine, etc), how much (a 6-pack, a case, etc.) or how often (daily, weekly, monthly). The primary issue is what happens as a result of the use and whether the use continues at the same level and/or increases. Examples of areas in which problems could appear include:

- family
- social (friends)
- emotional
- occupational
- school
- legal
- physical
- spiritual

One interesting phenomenon of chemical dependency is that even though there are obvious problems in those areas (usually several), the individual denies their existence. This denial is usually heard in such statements as:

> "I don't have a problem with booze (pills, pot, etc.)."
>
> "I can quit whenever I want to, I just don't want to."
>
> "It's all your fault."
>
> "If you were a better parent (spouse, friend) I wouldn't have to use like I do."

What is even more interesting (and frightening) is that the chemically dependent individual really begins to believe their own denial. The family also believes it after a while and accepts the guilt for "causing" the addict to use. This will be discussed more in the family section.

THE DISEASE CONCEPT

Over the years there has been a lot of controversy around the issue of disease vs. morality with chemical dependency. Due to some of the behaviors associated with addiction (loss of time at work, abuse toward family and friends, DUI's, etc.) many people hold the belief that addiction is a moral issue. They see the addict as a weak-willed, morally corrupt or bad person. The other school of thought, and the one that is usually found among treatment professionals, is that the individual is suffering from a disease. More and more evidence is available to support this view of addiction, but the controversy still exists.

Beginning as early as 1935, a physician by the name of Dr. Silkworth (who treated one of the founders of Alcoholics Anonymous) referred to addiction as a disease. He called it a double-edged sword: "an allergy of the body coupled with an obsession of the mind". In 1945 another physician, Dr. Jellineck, observed over 100 alcoholic patients and was able to identify signs and symptoms as well as stages of the disease. The chart on page 46 is based on his findings. In 1955 the American Medical Association published a monograph in which it defined alcoholism as a disease. The disease concept has been used by treatment centers for decades because it fits the experience of most therapists and it helps to alleviate the guilt that is associated with addiction. The individual can now say: "I'm a sick person who can get well again rather than a bad person". This does not remove the responsibility ("I must do what needs to be done to treat my disease and make amends for what I did while I was using."), but it does help the individual feel that they are worth recovery.

A disease is generally defined by dictionaries as a destructive process in an organism that has identifiable signs and symptoms and a specific cause (which may be known or unknown). Addiction is certainly a destructive process in many ways, not the least of which is physical. It can cause cirrhosis of the liver, heart disease and attacks, lung problems, stomach ulcers, and many other physical ailments. It is also destructive in more social/emotional ways through family problems, lost jobs, financial difficulties, and depression. With respect to signs and symptoms, we can look at the charts based on Dr. Jellineck's work to be able to predict the course the disease will take. As with all diseases, not every patient will experience every symptom in the exact same sequence, but we can make some pretty accurate predictions. Finally, comes the issue of cause. There is still a lot that is unknown about the causes of addiction, but one thing is clear. Although there may be a few people who become addicted by attempting to cope with another physical or emotional problem through "self-medication", in general addiction is primary. It is not caused by any other disease, nor is it a symptom of something else. Most research is now pointing to a strong genetic component to the causes of addiction which can be exacerbated by environmental and behavioral factors, (similar to other diseases such as diabetes, heart disease and cancer).

As a disease, chemical dependency has several characteristics. The disease is:

* primary (not a symptom of something else)
* chronic (no cure - lasts forever)
* progressive (gets worse over time)
* recurrent (relapse is common, particularly without proper treatment)
* fatal (if left untreated)
* treatable (through abstinence plus ongoing support such as AA)

The individual (adult or adolescent) involved in a recovery program from addiction knows that he/she: 1) is not a "bad" person, 2) will always be an addict, but can recover if they abstain from mood altering chemicals, 3) will find themselves in worse trouble, and eventually dead, if they do not remain abstinent, and 4) can recover from the addiction through abstinence and involvement in a 12-step program of recovery (this is discussed in more detail on pages 229-237). They also know that if they do not follow their program of recovery, that relapse can (and most likely will) occur.

ADOLESCENT RELAPSE

One of the questions that is frequently asked of adolescent substance abuse treatment providers is - "What is your recovery rate?" The answer to this question depends a lot on what the person means by "recovery". If they mean that the adolescent completes treatment and returns home never to use again, the answer is that very few adolescents "recover". This, of course, is not what people want to hear and they get very depressed, frustrated and angry. What they forget is that relapse is a part of the disease of addiction, just as it is with other chronic diseases. If they mean by "recovery" that the adolescent goes through treatment, returns home, experiences one or two brief relapses and learns through those experiences that they are, indeed, addicted, then the recovery rates are more promising. With adolescent recovery, relapse is very common and is often an integral part of the recovery process, which is why this section is included.

Adolescents by nature believe they are indestructible and that nothing bad can ever happen to them. They also tend to have experienced fewer problems from their use due solely to the fact that they have not used for as many years as many adult addicts. They can say to themselves: "That's never happened to me. And I feel fine now. I can probably handle it as long as I don't use too much." They are also faced with their old using friends every day when they return to school. In adult treatment programs people are told to stay out of places where there is use of chemicals going on (such as bars and cocktail parties). Adolescents, on the other hand, are told to return to school which is their "bar". A lot of adolescent drug use takes place in and around school. Additionally, very few adolescent parties are anything but "drinking and drugging" parties. Therefore, they are faced every day with peer pressure to use. The more support these adolescents receive in the form of aftercare programs and school-based support groups, the better their chances. But we need to keep in mind that most of them will experience at least a brief relapse.

Just as recovery from addiction is a process in which the person's physical, mental, social, emotional and spiritual health get progressively better, relapse is also a process, but one which heads in a different direction. There are many triggers for this process, some of which differ depending on the individual. But the fact remains that at some point in time, the recovering person finds their life starting to go out of control again. For many this leads to depression, anxiety and emotional pain. In the past, alcohol and other drugs took care of this type of pain and the temptation to fall back on this old method of coping becomes strong. For many adolescents, too strong to deny and they end up using again.

Relapse is not the end of the world, however. Most adolescents who use again begin to experience the same problems they had when they were using before. Often this is the push they need to get back into recovery again. "I guess they were right. It does keep getting worse. I can't use safely." For this type of adolescent, relapse becomes a learning process and makes for a stronger recovery. Others, however, give up and say "I blew it. I don't deserve to recover." They continue deeper and deeper into their addiction until they finally "hit bottom" and recover or die.

The key which determines the outcome of the relapse is often the people around the adolescent and the extent of support they receive. Again, the adolescents who experience the best success in recovery (complete abstinence or only an isolated relapse followed by abstinence) are the ones who are involved in a structured aftercare program that includes involvement in Alcoholics Anonymous (AA) and/or Narcotics Anonymous (NA). Support systems and/or groups within the school setting also increase their chances for recovery enormously.

Knowing the symptoms of relapse can help educators, parents and adolescents recognize the process before it gets out of hand. A model of this process has been developed by Tammy Bell from CENAPS Corporation. Relapse can be viewed through this model as a ten phase process beginning with denial and ending with the actual drinking behavior. More specifically, the phases are:

1. **Return of Denial** - The adolescent begins to withdraw from support systems. Thought processes occur which lead the adolescent to believe that they have things under control at the very time their recovery is beginning to fall apart.
2. **Avoidance and Defensive Behavior** - The adolescent begins to be more negative and defensive. They lose faith in the treatment system and try to do things their way.
3. **Crisis Building** - The adolescent's behavior and thinking become rigid and frenzied. Everything is a crisis with no solution.
4. **Immobilization - "If Only" Thinking** - The adolescent begins to use escape behaviors to deal with problems rather than facing them. They begin to experience mood swings and old behaviors.

5. **Confusion and Overreaction** - The adolescent now appears extremely hostile to everyone around them and is hyper-sensitive and hostile to criticism. They withdraw from AA/NA and other support systems and return to impulsive behaviors. At this point the whole family may return to old patterns of behavior.
6. **Depression** - The adolescent is becoming aware of their impairment but feels powerless to change. Family and friends are feeling frustrated and concerned.
7. **Behavioral Loss of Control** - Support from the family disintegrates as the adolescent's behavior gets progressively worse. They begin to accuse the adolescent of using even though the actual use has not yet happened.
8. **Recognition of Loss of Control** - The adolescent's behavior gets more and more explosive often resulting in fights at school, manipulation and attempts to control people and situations around them. "Euphoric recall" is common as the adolescent remembers past chemical use and drinking episodes that were "fun".
9. **Option Reduction** - The adolescent withdraws completely from all support systems. They tend to experience guilt, helplessness and hopelessness at this point which makes attempts to reach them futile.
10. **Acute Relapse Episode** - This is the stage of the actual use. Generally, the adolescent's drinking or drug use leaves them in a more severe physical and emotional state than they were prior to entering treatment the first time. Attempts at suicide become a possibility. Often family and friends are so frustrated at this point that they give up.

As with the progression of addiction, the sooner an intervention happens within the relapse process, the better the likelihood that the adolescent can return to recovery (perhaps without having to reach the final stage and actually use). A solid aftercare program, support systems in the school and an educated faculty can reduce (although not always eliminate) the likelihood of a serious relapse. Intervention and support will be discussed in more detail in the Student Assistance Program Section.

Percent ever used *

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	'86-'87 change
Approx. N =	9,400	15,400	17,100	17,800	15,500	15,900	17,500	17,700	16,300	15,900	16,000	15,200	16,300	
Marijuana/Hashish	47.3	52.8	56.4	59.2	60.4	60.3	59.5	58.7	57.0	54.9	54.2	50.9	50.2	-0.7
Inhalants (a)	NA	10.3	11.1	12.0	12.7	11.9	12.3	12.8	13.6	14.4	15.4	15.9	17.0	+1.1
Inhalants Adjusted (b)	NA	NA	NA	NA	18.2	17.3	17.2	17.7	18.2	18.0	18.1	20.1	18.6	-1.5
Amyl & Butyl Nitrites (c,h)	NA	NA	NA	NA	11.1	11.1	10.1	9.8	8.4	8.1	7.9	8.6	4.7	-3.9 sss
Hallucinogens	16.3	15.1	13.9	14.3	14.1	13.3	13.3	12.5	11.9	10.7	10.3	9.7	10.3	+0.6
Hallucinogens Adjusted (d)	NA	NA	NA	NA	17.7	15.6	15.3	14.3	13.6	12.3	12.1	11.9	10.6	-1.3 s
LSD	11.3	11.0	9.8	9.7	9.5	9.3	9.8	9.6	8.9	8.0	7.5	7.2	8.4	+1.2 s
PCP (c,h)	NA	NA	NA	NA	12.8	9.6	7.8	6.0	5.6	5.0	4.9	4.8	3.0	-1.8 ss
Cocaine	9.0	9.7	10.8	12.9	15.4	15.7	16.5	16.0	16.2	16.1	17.2	16.9	15.2	-1.7 s
"Crack" (g)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	5.6	NA
Other Cocaine (c)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	14.0	NA
Heroin	2.2	1.8	1.8	1.6	1.1	1.1	1.1	1.2	1.2	1.3	1.2	1.1	1.2	+0.1
Other Opiates (e)	9.0	9.6	10.3	9.9	10.1	9.8	10.1	9.6	9.4	9.7	10.2	9.0	9.2	+0.2
Stimulants (e)	22.3	22.6	23.0	22.9	24.2	26.4	32.2	35.6	35.4	NA	NA	NA	NA	NA
Stimulants Adjusted (f)	NA	NA	NA	NA	NA	NA	NA	27.9	26.9	27.9	26.2	23.4	21.6	-1.8 s
Sedatives (e)	18.2	17.7	17.4	16.0	14.6	14.9	16.0	15.2	14.4	13.3	11.8	10.4	8.7	-1.7 ss
Barbiturates (e)	16.9	16.2	15.6	13.7	11.8	11.0	11.3	10.3	9.9	9.9	9.2	8.4	7.4	-1.0
Methaqualone (e)	8.1	7.8	8.5	7.9	8.3	9.5	10.6	10.7	10.1	8.3	6.7	5.2	4.0	-1.2 ss
Tranquilizers (e)	17.0	16.8	18.0	17.0	16.3	15.2	14.7	14.0	13.3	12.4	11.9	10.9	10.9	0.0
Alcohol	90.4	91.9	92.5	93.1	93.0	93.2	92.6	92.8	92.6	92.6	92.2	91.3	92.2	+0.9
Cigarettes	73.6	75.4	75.7	75.3	74.0	71.0	71.0	70.1	70.6	69.7	68.8	67.6	67.2	-0.4

NOTES: Level of significance of difference between the two most recent classes: s =.05, ss =.01, sss =.001. NA indicates data not available

(a) Data based on four questionnaire form. N is four-fifths of N indicated

(b) Adjusted for underreporting of Amyl and Butyl nitrites. See text for details.

(c) Data is based on a single questionnaire form. N is one-fifth of N indicated.

(d) Adjusted for underreporting of PCP. See text for details.

(e) Only drug use which was not under a doctor's orders is included here.

(f) Based on the data from the revision question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.

(g) Data based on two questionnaire forms. N is two-fifths of N indicated.

(h) Question text changed slightly in 1987.

** From an annual survey done by University of Michigan Institute for Social Research*

Percent who used in last twelve months*

	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	'86-'87 change
Approx. N =	9,400	15,400	17,100	17,800	15,500	15,900	17,500	17,700	16,300	15,900	16,000	15,200	16,300	
Marijuana/Hashish	40.0	44.5	47.6	50.2	50.8	48.8	46.1	44.3	42.3	40.0	40.6	38.8	36.3	-2.5 s
Inhalants (a)	NA	3.0	3.7	4.1	5.4	4.6	4.1	4.5	4.3	5.1	5.7	6.1	6.9	+0.8
Inhalants Adjusted (b)	NA	NA	NA	NA	8.9	7.9	6.1	6.6	6.2	7.2	7.6	8.9	8.1	-0.8
Amyl & Butyl Nitrites (c,h)	NA	NA	NA	NA	6.5	5.7	3.7	3.6	3.6	4.0	4.0	4.7	2.6	-2.1 sss
Hallucinogens	11.2	9.4	8.8	9.6	9.9	9.3	9.0	8.1	7.3	6.5	6.3	6.0	6.4	+0.4
Hallucinogens Adjusted (d)	NA	NA	NA	NA	11.8	10.4	10.1	9.0	8.3	7.3	7.6	7.6	6.7	-0.9
LSD	7.2	6.4	5.5	6.3	6.6	6.5	6.5	6.1	5.4	4.7	4.4	4.5	5.2	+0.7
PCP (c,h)	NA	NA	NA	NA	7.0	4.4	3.2	2.2	2.6	2.3	2.9	2.4	1.3	-1.1 ss
Cocaine	5.6	6.0	7.2	9.0	12.0	12.3	12.4	11.5	11.4	11.6	13.1	12.7	10.3	-2.4 sss
"Crack" (g)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.0	NA
Other Cocaine (c)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	9.8	NA
Heroin	1.0	0.8	0.8	0.8	0.5	0.5	0.5	0.6	0.6	0.5	0.6	0.5	0.5	0.0
Other Opiates (e)	5.7	5.7	6.4	6.0	6.2	6.3	5.9	5.3	5.1	5.2	5.9	5.2	5.3	+0.1
Stimulants (e)	16.2	15.8	16.3	17.1	18.3	20.8	26.0	26.1	24.6	NA	NA	NA	NA	NA
Stimulants Adjusted (f)	NA	NA	NA	NA	NA	NA	NA	20.3	17.9	17.7	15.8	13.4	12.2	-1.2
Sedatives (e)	11.7	10.7	10.8	9.9	9.9	10.3	10.5	9.1	7.9	6.6	5.8	5.2	4.1	-1.1 ss
Barbiturates (e)	10.7	9.6	9.3	8.1	7.5	6.8	6.6	5.5	5.2	4.9	4.6	4.2	3.6	-0.6
Methaqualone (e)	5.1	4.7	5.2	4.9	5.9	7.2	7.6	6.8	5.4	3.8	2.8	2.1	1.5	-0.6 s
Tranquilizers (e)	10.6	10.3	10.8	9.9	9.6	8.7	8.0	7.0	6.9	6.1	6.1	5.8	5.5	-0.3
Alcohol	84.8	85.7	87.0	87.7	88.1	87.9	87.0	86.8	87.3	86.0	85.6	84.5	85.7	+1.2
Cigarettes	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

NOTES: Level of significance of difference between the two most recent classes: s =.05, ss =.01, sss =.001. NA indicates data not available
(a) Data based on four questionnaire form. N is four-fifths of N indicated
(b) Adjusted for underreporting of Amyl and Butyl nitrites. See text for details.
(c) Data is based on a single questionnaire form . N is one-fifth of N indicated.
(d) Adjusted for underreporting of PCP. See text for details.
(e) Only drug use which was not under a doctor's orders is included here.
(f)Based on the data from the revision question, which attempts to exclude the inappropriate reporting of non-prescription stimulants.
(g) Data based on two questionnaire forms. N is two-fifths of N indicated.
(h) Question text changed slightly in 1987.

* *From an annual survey done by University of Michigan Institute for Social Research*

Percent used in last thirty days *

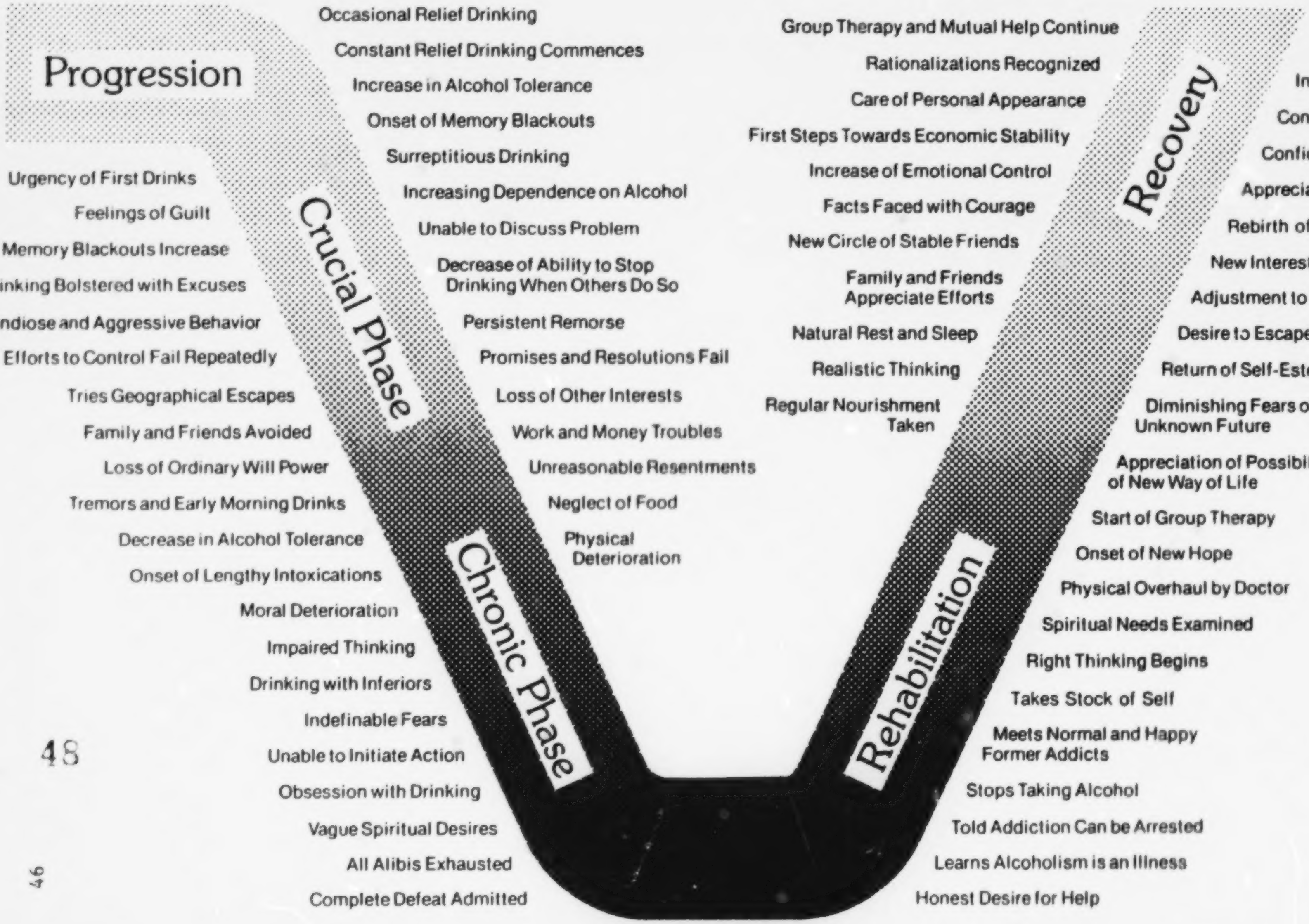
	Class of 1975	Class of 1976	Class of 1977	Class of 1978	Class of 1979	Class of 1980	Class of 1981	Class of 1982	Class of 1983	Class of 1984	Class of 1985	Class of 1986	Class of 1987	'86-'87 change
Approx. N =	9,400	15,400	17,100	17,800	15,500	15,900	17,500	17,700	16,300	15,900	16,000	15,200	16,300	
Marijuana/Hashish	27.1	32.2	35.4	37.1	36.5	33.7	31.6	28.5	27.0	25.2	25.7	23.4	21.0	-2.4 s
Inhalants (a)	NA	0.9	1.3	1.5	1.7	1.4	1.5	1.5	1.7	1.9	2.2	2.5	2.8	+0.3
Inhalants Adjusted (b)	NA	NA	NA	NA	3.2	2.7	2.5	2.5	2.5	2.6	3.0	3.2	3.5	+0.3
Amyl & Butyl Nitrites (c,h)	NA	NA	NA	NA	2.4	1.8	1.4	1.1	1.4	1.4	1.6	1.3	1.3	0.0
Hallucinogens	4.7	3.4	4.1	3.9	4.0	3.7	3.7	3.4	2.8	2.6	2.5	2.5	2.5	0.0
Hallucinogens Adjusted (d)	NA	NA	NA	NA	5.3	4.4	4.5	4.1	3.5	3.2	3.8	3.5	2.8	-0.7
LSD	2.3	1.9	2.1	2.1	2.4	2.3	2.5	2.4	1.9	1.5	1.6	1.7	1.8	+0.1
PCP (c,h)	NA	NA	NA	NA	2.4	1.4	1.4	1.0	1.3	1.0	1.6	1.3	0.6	-0.7 S
Cocaine	1.9	2.0	2.9	3.9	5.7	5.2	5.8	5.0	4.9	5.8	6.7	6.2	4.3	-1.9 sss
"Crack" (g)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	1.5	NA
Other Cocaine (c)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4.1	NA
Heroin	0.4	0.2	0.3	0.3	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.2	0.2	0.0
Other Opiates (e)	2.1	2.0	2.8	2.1	2.4	2.4	2.1	1.8	1.8	1.8	2.3	2.0	1.8	-0.2
Stimulants (e)	8.5	7.7	8.8	8.7	9.9	12.1	15.8	13.7	12.4	NA	NA	NA	NA	NA
Stimulants Adjusted (f)	NA	NA	NA	NA	NA	NA	NA	10.7	8.9	8.3	6.8	5.5	5.2	-0.3
Sedatives (e)	5.4	4.5	5.1	4.2	4.4	4.8	4.6	3.4	3.0	2.3	2.4	2.2	1.7	-0.5 s
Barbiturates (e)	4.7	3.0	4.3	3.2	3.2	2.9	2.6	2.0	2.1	1.7	2.0	1.8	1.4	-0.4
Methaqualone (e)	2.1	1.6	2.3	1.9	2.3	3.3	3.1	2.4	1.8	1.1	1.0	0.8	0.6	-0.2
Tranquilizers (e)	4.1	4.0	4.6	3.4	3.7	3.1	2.7	2.4	2.5	2.1	2.1	2.1	2.0	-0.1
Alcohol	68.2	68.3	71.2	72.1	71.8	72.0	70.7	69.7	69.4	67.2	65.9	65.3	66.4	+1.1
Cigarettes	36.7	38.8	38.4	36.7	34.4	30.5	29.4	30.0	30.3	29.3	30.1	29.6	29.4	-0.2

NOTES: Level of significance of difference betwe en the two most recent classes: s =.05, ss =.01, sss =.001. NA indicates data not available
(a) Data based on four questionnaire form. N is four-fifths of N indicated
(b) Adjusted for underreporting of Amyl and Buty l nitrites. See text for details.
(c) Data is based on a single questionnaire form . N is one-fifth of N indicated.
(d) Adjusted for underreporting of PCP. See tex t for details.
(e) Only drug use which was not under a doctor's orders is included here.
(f)Based on the data from the revision question, which attempts to exclude the inappropriate rep orting of non-prescription stimulants.
(g) Data based on two questionnaire forms. N is two-fifths of N indicated.
(h) Question text changed slightly in 1987.

* *From an annual survey done by University of Michigan Institute for Social Research*

The Progression and Recovery of the Alcoholic in the Disease of Alcoholism

To be read from left to right.



Occasional Relief Drinking

Constant Relief Drinking Commences

Increase in Alcohol Tolerance

Onset of Memory Blackouts

Surreptitious Drinking

Urgency of First Drinks

Increasing Dependence on Alcohol

Feelings of Guilt

Unable to Discuss Problem

Memory Blackouts Increase

Decrease of Ability to Stop Drinking When Others Do So

Drinking Bolstered with Excuses

Grandiose and Aggressive Behavior

Persistent Remorse

Efforts to Control Fail Repeatedly

Promises and Resolutions Fail

Tries Geographical Escapes

Loss of Other Interests

Family and Friends Avoided

Work and Money Troubles

Loss of Ordinary Will Power

Unreasonable Resentments

Tremors and Early Morning Drinks

Neglect of Food

Decrease in Alcohol Tolerance

Physical Deterioration

Onset of Lengthy Intoxications

Moral Deterioration

Impaired Thinking

Drinking with Inferiors

Indefinable Fears

Unable to Initiate Action

Obsession with Drinking

Vague Spiritual Desires

All Alibis Exhausted

Complete Defeat Admitted

Obsessive Drinking Continues in Vicious Circles

Honest Desire for Help

Learns Alcoholism is an Illness

Told Addiction Can be Arrested

Stops Taking Alcohol

Meets Normal and Happy Former Addicts

Takes Stock of Self

Right Thinking Begins

Spiritual Needs Examined

Physical Overhaul by Doctor

Onset of New Hope

Start of Group Therapy

Appreciation of Possibilities of New Way of Life

Regular Nourishment Taken

Diminishing Fears of the Unknown Future

Realistic Thinking

Return of Self-Esteem

Natural Rest and Sleep

Desire to Escape Goes

Family and Friends Appreciate Efforts

Adjustment to Family Needs

New Interests Develop

New Circle of Stable Friends

Rebirth of Ideals

Facts Faced with Courage

Appreciation of Real Values

Increase of Emotional Control

Confidence of Employers

First Steps Towards Economic Stability

Contentment in Sobriety

Care of Personal Appearance

Increasing Tolerance

Rationalizations Recognized

Group Therapy and Mutual Help Continue

Enlightened and Interesting Way of Life Opens Up with Road Ahead to Higher Levels than Ever Before

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"NIGHTMARE"

By Margie Pastrano

I looked out my window
And all I could see
Was a street full of chaos
And a contagious disease

A disease that will hurt you
A disease that will kill
A disease that can happen
By just popping a pill

I stand on the sidewalk
And I see children dying
I go into houses
And I see families fighting

Junkies and pushers
These are kids' models
And the toys that they play with
Are syringes and bottles

Is life really like this?
Is it really so bad?
Do I live in a world
That's completely gone mad?

But then I hear a voice
That is calling to me
Giving me hope
And setting me free

Free from my dungeon
Where I sat and I dwelled
Thinking that no one
Would come break this spell

But now I can see
That there are people out there
Who are fighting this nightmare
Because they really do care

But the nightmare goes on
So we continue to fight
Till the day we can say
That the nightmare has died

Printed from Prevention Express, May 1991

NICOTINE ADDICTION

The major focus of most Student Assistance Programs has, historically, been alcohol and other drug abuse. By "drugs" most people tend to mean things such as marijuana, cocaine, LSD, and heroin. For many years the drug alcohol was not included. Instead, it was dealt with as something different. Fortunately, this is becoming less true as people realize that alcohol is as much a drug as any pill or joint. What most people still don't think of with reference to drugs is nicotine. And yet nicotine is one of the most addicting drugs used in our society. It has a similar addiction potential (close to 100%) as crack or other forms of smokeable cocaine, and is used by a much higher percentage of the population.

Although there have been numerous smoking prevention programs over the years, the numbers related to nicotine addiction are still frightening:

* Children under the age of 18 purchase nearly one billion packs of cigarettes per year, even though 44 states restrict sales to minors.
* 3,000 adolescents begin regular smoking every day.
* Approximately 1 of every 6 American deaths is the result of smoking.
* The number of deaths attributable to cigarette smoking in the U.S. rose 11% from 1985 to 1988.

Some of the statistics are a bit more positive although they still show a need for continued prevention and treatment efforts.

- 49 million Americans are currently smokers; 40 million Americans are former smokers.
- 29% of the U.S. population were cigarette smokers in 1988 compared to 41% in 1965.
- 1.5 million Americans quit smoking annually, but 1 million Americans begin smoking each year (almost all of those being adolescents).

Understanding and addressing this issue within the framework of substance abuse prevention becomes critical, particularly given the fact discussed earlier that nicotine is a primary gateway drug for adolescents.

Nicotine has been a part of our society for centuries. It occurs naturally in the tobacco plant as a liquid substance. These leaves are dried to form the commonly used products such as cigarettes, cigars, pipe tobacco, and chewing tobacco. Nicotine is a stimulant in that it causes an increase in heart rate and blood pressure plus a drop in skin temperature. Nicotine causes an initial stimulation of the central nervous system followed by a reduction in activity. Long term effects include increased blood pressure and risk of strokes or heart attacks, cancer of the lungs, larynx, oral cavity or esophagus, and chronic bronchitis or emphysema.

We usually think only of the nicotine and tar in tobacco products as the culprits. What many people don't realize is that there are numerous other compounds and gases that cause problems. There are as many as 4,000 additional chemicals in tobacco smoke including carbon monoxide, carbon dioxide, hydrogen cyanide, traces of arsenic, ammonia, and carcinogens.

Unfortunately, the use of tobacco products continues regardless of the facts that are known. Why would people begin smoking, knowing that it causes so many long term physical problems including premature death? The reasons given are similar to the ones people have for starting to use any substance. Curiosity and a desire to appear adult top the list along with peer pressure to use. Some adolescents also see it as a way to rebel against parental authority. One frightening reason comes primarily from adolescent females (who are starting to smoke at the highest rates of any group). Many of them state that they started smoking to lose weight. Some people who smoke experience a loss of appetite. In this society where "thin is in" and where people want quick weight loss, rather than a healthier 1-2 pounds per week, smoking seems to some a way to reach this goal. And since all teens who start smoking (or using any other substance) believe "it will never happen to me," they look only at the short term effects not long term.

As cigarette smoking becomes less and less socially acceptable in the adult world, adolescents may follow suit. In the meantime, smoking prevention programs are attempting to address children by using short term effects to which they can relate. Many campaigns (both prevention and smoking cessation) emphasize the stained teeth and fingers, the smelly clothes and hair, and the money that gets spent each day on cigarettes.

Another tobacco product that has been getting a lot of attention is chewing tobacco and/or snuff. In 1985 scientists clearly stated that there is an unquestionable link between snuff and oral cancer (the nation's seventh leading cause of cancer death). The offending chemicals are the highly potent cancer-causing nitrosamines which form through the interaction of saliva and tobacco. Currently there are 6-10 million users of snuff with sales going up 8 percent each year. Smokeless tobacco is just as addicting as the smokeable form with most people who attempt to quit being unsuccessful. Much of the new use of smokeless tobacco is among young athletes who don't want to break training but want the lift they can get from nicotine.

A final issue that has arisen lately has to do with "sidestream" smoke. Although there are still arguments back and forth, research shows that non-smokers who are exposed to other people's smoke on a regular basis are more at risk for developing lung diseases. Children of smoking parents show a higher rate of respiratory symptoms and have an increased prevalence of bronchitis and pneumonia. As a result of these facts, more and more businesses, restaurants, public buildings, and even airplanes now provide non-smoking areas or outlaw smoking entirely. Most schools are eliminating "smoking areas" and some are banning all smoking for both students and staff. Although many smokers claim that their right to smoke is being violated, most non-smokers state "you have the right to smoke all you want, but you don't have a right to force me to inhale your sidestream smoke."

The controversy over smoking will probably continue for years to come. But the reality is that as smoking becomes less and less accepted in our society the decline in the percentage of Americans using tobacco products should continue to drop and many lives should be saved. One of the factors in encouraging this trend to continue will be smoking prevention and cessation programs within the school setting as opposed to treating nicotine as "different from other drugs". It may not cause the same behavioral changes as other drugs, but the physical damage and the addictive potential are just as serious if not more so. Let's keep the trend going of encouraging kids not to start and helping people who are already using nicotine to stop.

SUICIDE

> Dear Diary:
>
> No one knows I am alive or seems to care if I die. I am a **TERRIBLE**, worthless person who only causes others sadness and pain. It would have been easier if I had never been born. Tabby was my only friend in the world and now she is dead. There is no reason for me to live anymore....
>
> -Lisa, 16 years old
> (Tabby was her cat)

There is a myth in our society that childhood and adolescence are carefree, happy-go-lucky times. Even though most people would admit that adolescence is a time of turmoil and change, many young people are still told: "These are the best years of your life. Enjoy them while you can before you have to be a responsible adult with all the stress and difficulty of being grown up." We don't like to admit that young people would get depressed enough to want to end their lives "before they have even begun," but the reality is that more and more adolescents (and even younger children) are depressed and suicidal.

* Each year more than one million adolescents attempt suicide (approximately 1 every 90 seconds).
* More than 6,000 young people successfully commit suicide annually (18 per day).
* Suicide is the second leading cause of death for adolescents. Accidents rank first (and many accidents may actually be suicides).
* One in five girls and one in ten boys in the 8th and 10th grade say they have attempted suicide at least once.

- 80% of adolescents who attempt suicide communicate their intentions verbally prior to their attempt and the other 20% communicate the notion that they are at risk through their behavior.
- Adolescents who attempt suicide tend to be female by a ratio of 4:1. 90% of these youngsters try to kill themselves by ingesting drugs.
- Adolescents who complete the suicide act tend to be male by a ratio of 3:1. Two-thirds of them kill themselves with a gun.

All of these add up to a picture of a generation of risk.

To combat these statistics schools, parents, and communities are having to talk about a topic that most people would rather keep hidden. But talking about it is one way to begin to address the growing problem of adolescent suicide. We need to address the reasons for the growing numbers of adolescent suicides and how we can prevent them as well as the signs and symptoms of a suicidal child. Then comes the issue of intervention with suicidal youngsters and postvention in the event that the attempt is successful.

THEORIES REGARDING ADOLESCENT SUICIDE:

There is no one answer to the increase in adolescent suicide. For each child, the motivating factors may be different. However, there are some overall patterns that exist in common for each child. The most prevalent and obvious is that suicide is a cry for help. Regardless of why the child feels they can't go on, they are attempting to reach out to others to stop their pain.

There is a lot of ambivalence for the adolescent who is suicidal. They don't particularly want to die, but they don't want to keep living the way they are and don't know how to ask for help. Consequently, many suicide attempts are done in such a way and at such a time as to be sure that someone stops them. They also tend to give signals as to their intent for several months prior to the attempts. These will be discussed in more detail later.

The suicidal adolescent is generally experiencing three primary feelings: Helpless, Hopeless, and Isolated. These feelings combine together to cause the youngster to feel trapped. Nothing can ever be positive again. There seems to be no way out. This feeling gets particularly strong when the adolescent is told: "You have so much to live for" or "These are the best years of your life." Imagine feeling helpless, hopeless, and isolated and then being told that this is as good as it gets.

There are many factors leading to these feelings of helplessness, hopelessness and isolation. One is the nature of adolescence itself and the depression that often accompanies this life stage. Adolescence is a time of extreme change. Kids have to deal with their changing bodies, increasing responsibilities, new dynamics to relationships (especially with the opposite sex), and growing struggles for independence. Choices must be made that will effect their lives years down the road. Choices regarding college, careers, lifestyles, and values. For many young people this becomes more than they can handle. And often, due to the increase in single-parent homes or two career homes, they don't have access to support systems. Consequently, they may reach a point where they see no options other than ending their life.

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A second factor in adolescent suicide is the pressure and stress these kids feel to succeed. Although this pressure has been there in other generations, it has gotten stronger over the years. With fewer and fewer paths to success that don't involve a lot of college and with colleges tightening their enrollment requirements, kids feel enormous pressure to get good grades. On the other hand, they also see that good grades and college are not a guarantee as they watch adults around them get laid-off or fail to have their salaries keep up with inflation. They begin to wonder why they should even try, and yet the pressure to succeed is still there. Each generation has wanted their children to do better than them educationally, professionally, and financially. But there is a limit to how far people can go, and we are now looking at the first generation that will probably not (on average) surpass their parents. And yet the pressure to do so continues. "Winning is everything." Therefore, when they don't live up to the expectations for success (their own or others') they feel like a total failure and may see no reason to continue trying. Certainly, low self-esteem ties into this factor. A child who feels good about themselves can set more realistic goals and accept when they don't quite reach them. A child who does not feel good about themselves will tend to count on their goals to make them feel better and will be devastated by falling short.

A third factor is isolation and alienation. As adults we often have a hard time expressing our feelings to each other. This means that kids don't learn to communicate on a feeling level. Consequently, when they feel depressed, anxious, angry, scared, or lonely (all very normal feelings) they may think that no one understands or feels the same way. They end up feeling alone and isolated, even when they may be the most popular kid in school. Then there is the adolescent desire to fit in and "be like" everyone else. This results in many kids hiding feelings they perceive as different or weird. The result is best described in the following:

ON SCHOOL

He always wanted to explain things
But no one cared.
So he drew.
Sometimes he would draw,
and it wasn't anything.
He wanted to carve it in stone
or write it in the sky,
and it would be only him and the sky and
the things inside him that needed saying.
It was after that he drew the picture.
It was a beautiful picture.
He kept it under his pillow
and would let no one else see it.
He would look at it every night
and think about it.
When it was very dark and his eyes were closed,
he could still see it.
When he started school,
he brought it with him,
not to show anyone,
just to have it along like a friend.
It was funny about school.
He sat at a square, brown desk,
like all the other square, brown desks.
He thought it should be red.
And his room was a square, brown room,
like all the other rooms.
It was tight and close and stiff.
He hated to hold the pencil and chalk,
his arms stiff, his feet flat on the floor,
stiff,
the teacher watching and watching.
She came and spoke to him.
She told him to wear a tie,
like all the other boys.
He said he didn't like them.
She said it didn't matter!
After that, they drew.
He drew all yellow.
It was the way he felt about morning.
And it was beautiful.
The teacher came and smiled at him.
"What's this?" She said. "Why don't you
draw something like Ken's drawing?
Isn't that beautiful?"
After that his mother bought him a tie,

And he always drew airplanes and rocketships
like everyone else.
And he threw the old picture away.
And he lay alone looking at the sky,
it was big and blue and all of everything,
but he wasn't anymore.
He was square inside and brown,
and his hands were stiff.
He was like everyone else.
The things inside that needed saying
didn't need it anymore.
It had stopped pushing.
It was crushed.
Stiff.
Like everyone else.

Written by a High School Senior -- Two weeks before
committing suicide.

Related to isolation and loneliness is the existence of a significant loss. Since many children may be experiencing loss for the first time, they do not know how to cope. This becomes a time when we as adults need to teach them how to deal with grief and yet we often miss the opportunity. One reason the opportunity gets missed is that the parents may be involved in the loss also. If it is a divorce or death in the family, the parents may be too wrapped up in their own grief process to be able to help the child. The second reason that adults may miss the opportunity to help guide a child through the grief process is that we may not recognize it as a significant loss. An adolescent who has just broken up with a boyfriend or girlfriend may be devastated as they have not been through this process. We may look at it and shrug saying: "Someone else will come along. You were only going out for a few months, you'll feel better soon." Or a child loses a favorite pet and although the parents are also sad, they don't equate it with death of a loved one. For that child, however, the pet may have been a close companion for most of their life. In addition, it may be the first experience they have had with death. All of these situations can become triggers for the child to feel hopeless, helpless and isolated and to consider ending their life.

A final factor that needs to be mentioned is the use of drugs. As the use of alcohol and other drugs (particularly depressants such as alcohol) increase, the suicide rate has also increased. There is a definite correlation between the two. Researchers have found that there is a 30% higher rate of suicide among kids who abuse alcohol and other drugs than those who don't. And as was mentioned earlier, 80% of adolescents who attempt suicide have been drinking at the time.

In looking at these factors, prevention programs that decrease drug use, increase self-esteem, and encourage and teach kids to talk about feelings will help to decrease the rate of adolescent suicide. We need to help kids learn how to set realistic goals and how to accept when they don't quite achieve what they wanted. We need to model talking about feelings so they can find out that they are not alone in feeling sad, lonely, scared, isolated, or angry. And finally, we need to be very open about suicide being a reality, but not the answer, and let kids know where they can go for help. It is especially important to let kids know that they can (and should) help their friends who are suicidal by telling an adult. Often other kids are the first to know if someone is suicidal, but they don't want to "narc" on their friend. Part of suicide prevention and education needs to be letting kids know that the way to be a good friend is to tell someone who can help.

SIGNS AND SYMPTOMS:

As we stated earlier, most kids exhibit warning signs as part of their cry for help prior to the actual attempt. If we can learn to recognize these signs, we can offer the child the help they want. Some common signs and symptoms of adolescent suicide ideation are (from: Youth Suicide - A School Approach for the Prevention of Youth Suicide in Indiana, Indiana State Board of Health, 1985.):

Acting out: aggressive, hostile behavior, truancy, cutting classes

*Abrupt changes in personality

*Sudden mood swings (sudden positive behavior following a period of especially serious depression)

*Giving away prized or personal possessions

*Obsession with death; a death wish; death themes in drawings and poetry

*Discussion of suicide or making a suicidal plan

Accident prone

Alcohol and drug abuse

Passive behavior

Changes in eating habits

Changes in sleeping habits

Fear of separation

Impulsiveness

Slackening interest in school work and decline in grades

Inability to concentrate

Loss or lack of friends

Loss of an important person or thing in the child's life

*Hopelessness, helplessness, and anger at self and the world

Writing a lot of letters

*Previous attempt!!

*Scratching, self-mutilation, or other self-destructive acts

*These cues are indicative of a high potential for suicide, particularly if depression and/or substance abuse is present.

Since depression is mentioned as an exacerbating factor to the symptoms of suicide it needs to be addressed here. Most adolescents experience mood swings and depression as a part of this stage of life. The key to problematic depression is the DURATION AND INTENSITY of the symptoms. If the behaviors listed as warning signs for depression last longer than two weeks or cause impairment in normal functioning, there is reason to be concerned. The following list includes the symptoms of depression with the asterisks (*) indicating those that are often masked symptoms of teenage depression (from: Youth Suicide - A School Approach for the Prevention of Youth Suicide in Indiana, Indiana State Board of Health, 1985):

*Feelings of emptiness in life, loss of interest in usual activities

*Risk-taking behavior (driving fast, recklessly)

*Rebellious refusal to work in class or cooperate in general

Sadness (in children under six years of age, may be inferred from a persistently sad facial expression)

Anger and rage--typically expressed by verbal sarcasm and attack (angry outbursts)

Inability to concentrate or make decisions

Sensitivity with inclination to overreact to criticism

Fluctuations between indifference and apathy on one hand and talkativeness on the other

Feelings of insufficiency to satisfy ideals

Poor self-esteem (self-criticism and blame, sense of personal failure)

Feelings of helplessness and decreased peer support

Withdrawing from friends, excessive television watching

Intense ambivalence between dependence and independence

Restlessness and agitation (inability to relax)

Mood swings--the quiet youngster becoming hyperactive, the outgoing youngster becoming withdrawn

Pessimism about the future

Death wishes; suicide ideas, plans, and attempts

Sleep disturbance (decreased or increased)

Increased or decreased appetite

*Weight gain or loss (anorexia)

*Somatic problems (e.g., headache, stomachaches)

SUICIDE INTERVENTION:

Although intervention in general will be discussed later under Student Assistance Programs, suicide is a specific category which requires a little different approach. Because suicidal ideation and attempts are considered a crisis, it is helpful to view the intervention process in much the same way as you would a plan for dealing with a fire. Just as schools have a specific plan for evacuation that is posted in each room, reviewed regularly, and practiced at random times, so too there needs to be a set plan for dealing with suicide. This plan needs to be reviewed regularly with copies distributed to all staff (not just classroom teachers) and, if possible, situations role-played several times per year. At minimum, an inservice for staff regarding suicide is required on an annual basis.

Each "firedrill" plan for suicide is going to be slightly different depending on the school. However, they will all have some things in common that will answer the following questions:

1) **Who do I go to?** - If I am concerned about a student, I need to know who the designated people are within the school to whom I will turn. Generally, this needs to be a team of people instead of one (to provide back-up in case someone is out ill or at a conference). This team is usually made up of people such as the principal or other administrators, counselor, nurse, psychologist, social worker, etc. These people will not determine the appropriate treatment, but will instead act as a "clearinghouse" or "referral service" for the child.

2) **What happens once the child has been identified?** - There are several considerations here. One is to take all suicide threats seriously. Even if the child is "just looking for attention" it is an indication of a problem. Second is that the parents need to be notified and engaged in the process. There also needs to be a plan of action if the parents refuse to take the threat seriously. Finally, if a child is threatening suicide, there needs to be someone with them at all times who can be supportive, non-judgmental, and caring.

3) **Where do we refer?** - Suicide is an issue that is not appropriate to deal with in schools. The plan needs to identify outside resources who are available to conduct an assessment and make recommendations as to further action. **It should not be up to the child, parents, or school personnel to determine when the crisis is over.**

4) **Who will follow up?** - It is important for someone to follow up with the family, child, or referral source to make sure that the child got there and that their needs are being met. This also

provides an opportunity to find out what role the school can plan in supporting the child and family (work being provided while the child is in treatment, schedule change to permit time for counseling, etc.).

Again, the plan to meet all of these concerns needs to be written down **ahead of time** and all staff should know the steps to follow. Don't wait until a crisis occurs to develop a plan.

There are some general guidelines to follow if you suspect that an adolescent is considering suicide.

1) **Discuss the issue openly:** Most of us are afraid that by mentioning suicide we will "put the idea into their head." If a child is not considering suicide, talking about it won't make them want to kill themselves. If they are thinking about it, bringing up the topic in a way that is open, caring, and non-judgmental may allow them to get some relief from their pain.

2) **Demonstrate care and concern:** Most kids who are suicidal think that no one cares about them. By listening to them and validating their feelings you can help alleviate some of the isolation. This is where it is important to not discount them by saying: "But why would you feel like that? You have so much going for you." They don't perceive it that way. Listening is the best support you can offer.

3) **Get help:** Don't try to handle it on your own. You will run into issues of confidentiality here. Just tell the child that what they have told you is beyond what the two of you can handle and you want to be sure that they get help. Generally, kids know that you will have to tell. Just do it in such a way that you reassure them of your intention to help.

4) **Do not leave them alone:** This bears repeating. It is especially crucial if they have a clear plan of action or have had previous suicide attempts.

5) **Take care of yourself:** You will feel drained, scared, and may not be sure you did the "right" thing. Be sure that you have someone you can go to and process what happened. Often a member of your school's crisis team is a good person with whom to discuss the situation.

Finally, remember that even if you follow all of these guidelines, there will be a small percentage of kids who are determined to die no matter how well you intervene. Make sure you have support if this happens so you don't end up blaming yourself.

SUICIDE POSTVENTION:

Despite all of the school's good intentions, there will be kids who die. Some of these may be suicide, others may be accidents, illnesses, and even homicides. Regardless of the cause, the whole school goes into shock and a plan of action needs to exist (prior to the event) to help people deal with the tragedy.

The first consideration in a postvention plan is that everyone in the school will need to have a place to find out about the death in a factual way and talk about their feelings. If possible, talking about the death in a classroom setting (as opposed to an assembly) allows students to talk more freely and provides a better opportunity to identify kids who may need further help. The death needs to be reported in a way that dispels rumors, provides the necessary information without going into all the details, and takes away any glamorization that may occur. School staff will also need a place to discuss their feelings either in a faculty meeting or in smaller groups such as department meetings. If possible, it is also helpful to ask agencies to provide staff to supervise a "drop-in" room where people can come throughout the day to discuss their concerns and deal with their grief. If a school has "peer helpers" these students can also be used to help other kids talk about their feelings, but be sure that the helpers have a place to go to be helped. Schools often hold a parent meeting to discuss the death in a factual way and to provide some training as to what parents can look for at home.

The postvention plan needs to include a process for identifying other students who may be at risk. This is especially true with a suicide. Often, one suicide can turn into a cluster as other depressed students see it as an option. Close friends of the deceased student need to be provided with a place to talk about their anger, guilt, and sadness. These kids need to be identified and observed for signs of depression and suicide. Using the incident as a way to raise the level of awareness can help in identifying other students who were slipping through the cracks. Then the intervention plan gets put into place.

The school also needs to address the issue of the media and coordination of efforts to avoid glamorizing the death in any way. Decide what to share with them in as factual a way as possible. Have all interaction go through one designated person (usually the principal) so that there is as little disruption in the school as possible. Most importantly, focus on what the school is doing to prevent future tragedies rather than focusing a lot of attention on "ain't it awful".

Keep in mind, that no matter how clear your postvention plan may be, the repercussions of a suicide or other tragic death in a student (or staff member) can linger for up to two years. Often there will be a resurgence of feelings on the anniversary of the death so be prepared (but be careful of setting up a "self-fulfilling prophecy"). The important thing is that postvention can (and often does) become prevention as kids who are depressed but not yet actively suicidal get identified and receive help. The key is to talk about the issue and develop plans even through it may be painful.

KIDS AND GANGS

> When you're a Jet, you're a Jet all the way.
> From your first cigarette to your last dying day.
> -West Side Story-

Gangs have become a reality of life for schools and communities in many areas of the country. Tight-knit gangs have moved from the inner city to suburbs and small towns bringing a myriad of problems with them. There are many types of gangs and many reasons for joining a gang. A 1990 study by the University of Chicago examined gangs in 45 cities nationwide and found 1,439 gangs with 120,636 members. The average age of these gang members has dropped to 13½ years old as opposed to 15 in 1984. And since the odds are against a child ever leaving a gang once involved, there is a strong need for schools, communities and parents to work together toward preventing gang involvement.

The profile of gangs has changed dramatically. The street gangs of the 1950's were viewed as teenage rebels in black leather jackets who hung out on street corners and met in back alleys to "rumble" with rival gangs. Today's gangs are far more violent, have increased mobility, and often possess a total disregard for human life. They are also no longer made up of only inner-city, black or hispanic, poor youth. More and more affluent white youth are joining traditionally black or hispanic gangs or are forming their own gangs. Finally, previous gangs were based on ties of friendship and organized around community "turf". Today, gangs are based on material profit and are organized around violence and illegal activity (most often drug dealing).

There are three predominant types of gangs currently existing in schools and communities. The first are "social gangs". This group is made up of kids who band together for the purpose of social connections and tend to be more characterized by school cliques and "wanna be" gang members. They act like and dress like gang members but are not usually involved in serious gang activity. The only problem this group poses in school is that larger gangs can often recruit them to support violent activities in school. Generally they remain outside of the arena of hard core gang activity.

The second type of gang is known as the "delinquent gangs". These are more organized and tend to be involved in direct illegal behavior. They have frequent police contact, but this generally does not stop them from causing major problems on school campuses. Their primary activities tend to involve graffiti, vandalism, acts of defiance, assaults on younger or weaker students, and drug dealing.

The final type of gangs are the "violent gangs". This group has frequent and serious police contact as a result of their acts of violence. Their goal in committing violent acts tends to be some form of psychic gratification. They tend to be several years behind in school and can cause numerous problems since they feel no bonding to the educational process and feel justified in causing a disruption.

There are many reasons for joining a gang ranging from attempts to shock parents to the pursuit of easy money to the misguided sense of romance of gangs. The primary reasons, however, tend to be a search for identity, the need for protection, a desire for fellowship or brotherhood, and a response to intimidation. Interestingly, in interviews with gang members, many don't have a clear picture of why they joined. For many it "seemed like the thing to do at the time". For schools, communities, and parents an understanding of what motivates kids to join gangs can help in developing prevention programs.

The first motivation mentioned is identity. If a child feels insignificant and unimportant, they can gain a level of recognition in the gang that they have not previously experienced. Gangs also tend to develop along racial lines so the identity may be with one's culture. This often takes the form of "us against them" as the gang sees itself as protecting its culture and racial identity from the outside world. There are two crucial points here for prevention. First, we need to find ways for kids to feel important in other ways. Second, our society may need to find a way to be a "melting pot" without forcing people to give up their racial identity. To do this without seeing one culture as better or worse than another will be difficult, if not impossible, but needs to be addressed. Programs that focus on multi-cultural issues and help develop an appreciation for other customs and racial identities may be one answer.

The second reason for joining a gang is protection. This is particularly true for kids who live in neighborhoods where violent crime is an everyday reality. Unfortunately, this has become a vicious circle. Gangs formed in response to violence and began to be involved in violent acts which then increased the need to be in a gang which then increased the violence, and so on. Young children are now forced to align themselves with a gang in order to have protection both at home and at school. Many schools and communities have begun implementing neighborhood watch programs and increasing security in schools and neighborhoods with the goal of making them safer. A strong and consistent policy regarding gang activity and violence can be very helpful. When this policy is supported by youth and other police officers in the community progress becomes possible.

A third reason given for gang membership involves a search for fellowship and brotherhood. Many kids who get involved in gangs have no real family or may feel very disconnected. If a tight family structure is missing in the home, children will attempt to find it elsewhere. The increase of single-parent families and the poverty level of many have lead to families where children are often left to fend for themselves. Even more affluent families where both parents work can lead to the same feeling of isolation and emptiness. For these children, the gang becomes their family and leads to a fierce loyalty to the other gang members. Parenting programs for young single mothers who often have limited parenting skills, after school programs and courts holding parents accountable for their child's behavior are some of the attempts to address this area.

Finally, kids join gangs as a result of intimidation. This actually falls in the same category as protection, but with a little different flavor. New members are forced to join through threats, beatings and other violence. The bottom line for many kids becomes "join or be killed". As with protection, security tactics become the best tool in preventing gang involvement motivated by intimidation.

In general, prevention of gang involvement requires the same comprehensive approach as other prevention programs. There needs to be a balance between law enforcement efforts (including punishment for serious offenders) and school/community efforts which would include recreational programs, parenting classes, peer involvement, and educational programs for parents, teachers, community members and young people. Any program that will help kids feel more positive about themselves, offers them alternatives and teaches them how to make healthy choices will eventually make a dent in the increase of gang involvement by young people. And although it won't be easy or quick, the sooner schools, parents, law enforcement, community leaders and students work together, the sooner the dent will begin.

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AN OPEN LETTER TO MY FAMILY

I am a chemically dependent person. I need help.

Don't allow me to lie to you and accept it for the truth, for in so doing you encourage me to lie. The truth may be painful, but get at it.

Don't let me outsmart you. This only teaches me to avoid responsibility, and to lose respect for you at the same time.

Don't let me exploit you or take advantage of you. In so doing, you become an accomplice to my evasion of responsibility.

Don't lecture me, moralize, scold, praise, blame or argue when I'm drunk, high or sober. And don't pour out my liquor, or take away my drugs. You may feel better, but the situation will be worse.

Don't accept my promises. This is just my method of postponing pain. And don't keep switching agreements. If an agreement is made, stick to it.

Don't lose your temper with me. It will destroy you and any possibility of keeping me.

Don't allow your anxiety for us compel you to do what I must do for myself.

Don't cover up or abort the consequences of my chemical use. It reduces the crisis, but perpetuates the illness.

Above all, don't run away from reality as I do. Chemical dependency, my illness, gets worse as my use continues. Start now to learn, to understand, and to plan for my recovery. I need help from a doctor, a counselor, a psychologist, other recovering alcoholics or addicts, and from God. I cannot help myself.

I hate myself, but I love you. To do nothing is the worst choice you can make for us.

Please help me.

You Chemically Dependent Person

CHILDREN OF DYSFUNCTIONAL FAMILIES

> My father didn't tell me how to live;
> he lived, and let me watch him do it.
> -Clarence Budington Kellard-

Regardless of the emotional health of the family and the quality of the relationships, the primary place for children to learn about themselves and the world around them is the family. They learn who they are, how to act, what relationships are all about, and whether or not they are safe. It is estimated that between 25 and 28 million children in our society are affected by a chemically dependent parent. There are many more children who are victims of abuse, whose parents experience severe marital difficulty or divorce, who live with a parent suffering from mental illness, or any number of other factors that can create chronic stress and pain. This seriously affects what children learn about how to live.

Family Systems:

To understand what these children learn and the effects this learning can have on their lives, we must first examine the family. Families serve a variety of purposes. First, and perhaps most important, they help develop the child's sense of self-worth. They help answer the question: "Am I loveable, capable and significant?" Second, families teach children how to communicate with others. Various styles of communication exist depending on our experiences growing up. Third, they teach children the necessity of following rules and give them opportunities to practice. Fourth, they connect the child with their culture and/or with society at large. And finally, families prepare the child to live a productive, independent life.

The ultimate goal of the family is to have a child emancipate and move out into the world as a functional member of society. How well the family functions will have a direct impact on how successful this emancipation is and how independent the child is able to be. In short, a functional family generally produces a functional child and a dysfunctional family produces a dysfunctional child. This rule does not hold true 100%. Some children from dysfunctional families are able to be "resilient" and become healthy, functional adults, but in most cases dysfunction breeds dysfunction.

The first step in being able to help children who come from dysfunctional families is to be able to recognize them. And the first step in this process is to understand families and how they function (or don't function). The fact of the matter is that families are not either/or. There is a continuum of "functionality" on which they fall:

Families can exist anywhere on this continuum depending on how severe the problems are and how entrenched and rigid the characteristics of functionality become. Each end of the continuum has its own characteristics which will be discussed in more detail.

Functional Families:

A functional family has characteristics which allow members to feel loveable, significant, and safe. These characteristics are:

1) **An affiliative attitude:** The family feels like a unit and feels good about being a unit. There are connections and bonds between members, yet no one is held too close.

2) **A respect for autonomy:** Although there is a bond, there is also a sense of individuality. Each member is seen as unique and important with a specific "gift" to bring to the family.

3) **A hierarchy:** Many families have tried to create a "democracy" with very negative results. Families are more like "benign dictatorships". There needs to be a hierarchy in which the parent or parents are in charge. There also needs to be a parental coalition (even if the parents are not still married to each other).

4) **Initiative:** The functional family is able to take problems they face (and all families will face them) and come up with creative and flexible ways in which to handle them.

5) **Spontaneity:** This relates to the family's ability to meet challenges as well as the ability to have fun and enjoy life. Most important, it means that if things don't work exactly the way they are supposed to, the family is able to adjust positively.

6) **Value placed on outside relationships:** Healthy families are open to input and relationships with the "outside world". Without these relationships, the family can get stuck in the same old patterns and never grow. Also, since the ultimate goal is to have the children move out into the world, these connections are important.

7) **A method for conflict resolution:** Being a functional family does not mean that there is never any conflict. What it does mean is that the family has an accepted method for negotiation within specific boundaries.

8) **A congruent family image:** This is sometimes a tough one because it means being honest about what is happening even when that is hard to do. The family acknowledges problems as well as successes in order to create a real picture of the system for themselves and people around them.

9) **Rules and roles that make sense:** The rules and roles that we experience in a family become guidelines for behavior and, hopefully, promote predictability. These need to be flexible in order to adapt to changing situations as well as the developmental stages of the child. Functional families are able to be flexible with their rules and roles, within identified boundaries.

10) **Productive communication:** Functional family members learn to communicate (to send and receive messages) clearly, directly, and congruently. They are able to communicate about feelings in addition to facts, which allows the relationships in the family to be strengthened.

These characteristics lead to an optimally functioning family. But, as with most theories, they only work to perfection in textbooks. Most families, even the most functional, do not always experience each of these characteristics totally. What we can say about the functional family is that they experience most of these characteristics most of the time.

Virginia Satir developed a way of comparing some of the previous characteristics, plus some additional ones, as they would exist in an optimally functioning family and a dysfunctional family.

Arenas	**Optimal Functioning**	**Dysfunctional**
Self-Worth	High	Low
Communication	Direct	Indirect
	Clear	Unclear
	Specific	Unspecific
	Congruent	Incongruent
	Placating	Blaming
	Involved	Detached
	Leveling	Distracting
	(Growth Producing)	(Growth Impeding)
Rules	Overt	Covert
	Up-to-Date	Out-of-Date
	Human Rules	Inhuman Rules
Outcome	Realistic	Accidental
	Ordered	Chaotic
	Appropriate	Inappropriate
	Constructive	Destructive

The optimally functioning family will tend to be "change enhancing" whereas the dysfunctional family is "change resistant". The overall outcome with respect to self-worth is that in the functional family the child's self-worth grows more reliable and consistent and becomes more internalized. In the dysfunctional family the child grows to doubt their self-worth and must rely more and more on outside support.

Dysfunctional Families:

Dysfunctional families can exist for many reasons. Much of what is known about the characteristics of a dysfunctional family comes from work with alcoholics and their families. However, the same characteristics have been found in families where there is abuse, severe marital dysfunction, mental illness, or a compulsive behavior (workaholism, compulsive gambling, an eating disorder, etc.). The primary characteristic which defines a dysfunctional family is that there is chronic pain which is not being handled in any constructive way.

In a dysfunctional family, there are very different characteristics from those found in a functional family. In understanding these, it is important to note that they happen over time. Since they happen gradually, the family unconsciously adapts to each characteristic and sees it as "normal". Soon, the members of the family don't have any clear notion of what a healthy family looks like. They stare in disbelief at TV families such as the Cosbys and don't understand families that function different from theirs. We also know that they will tend to create a family similar to the one they grew up in when they marry and have children (daughters of alcoholics have a very strong tendency to marry an alcoholic).

Most of the characteristics of the dysfunctional family can be summarized in three rules by which people live:

1) **No Talk:** One of the first things a child learns in a dysfunctional family is that we don't talk about the dysfunction. This means to anyone outside the family in particular (we wouldn't want them to know what is going on), but it also includes each other. Consequently, most kids living in a dysfunctional family begin to doubt their own perceptions. They see Mom or Dad drinking every night and when they bring it up they are told it isn't the way it looks and it's really not that bad. They especially learn that it's not OK to talk about feelings which leads to the next rule.

2) **No Feel:** Most of the feelings that kids experience growing up in a dysfunctional family are painful. They include things such as anger, hurt, guilt, loneliness, and inadequacy. Since they can't talk about what is going on, they learn to suppress these feelings and to cover them up with survival roles (discussed later) which

protect them. Often these children get to the point where they honestly do not know what they are feeling.

3) **No Trust:** Most children from dysfunctional families (in particular those where alcohol or other drugs are involved) experience a whole series of broken promises and rejection from the people they trust most. There is little predictability in the family and kids often get to the point where they aren't quite sure what or who to believe. Their needs for love and attention have to take a back seat to the family's need for survival. Therefore, they quickly learn not to trust anyone.

All of these rules have one primary purpose; to help the family survive and deal with on-going crisis.

The damage and the need for survival in the face of chaos does not generally end when a child leaves the family. Experiences of therapists all over the country has led to the identification of a syndrome known as "Adult Children of Dysfunctional Families". The initial cases dealt with families where there had been alcohol or other drug abuse, but the same characteristics have been found in adults who grew up in other types of dysfunctional homes. The primary characteristics identified are that adult children:

1) have to guess at what normal is.
2) have difficulty following a project through from beginning to end.
3) lie when it would be just as easy to tell the truth.
4) judge themselves without mercy.
5) have difficulty having fun and take themselves very seriously.
6) have difficulty with intimate relationships.
7) overreact to changes over which they have no control.

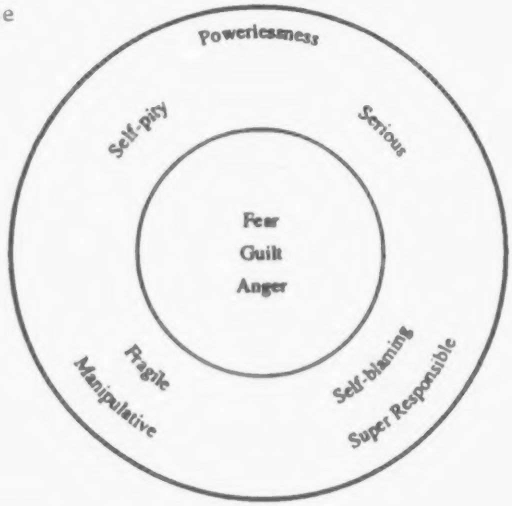
8) constantly seek approval and affirmation.
9) feel that they are different from other people.
10) are either very responsible or very irresponsible.
11) are impulsive.

Most of these characteristics are ones that these children learned growing up and that they carry with them into adulthood unless they get some help.

The survival roles that develop in dysfunctional families (and that usually lead to the adult child characteristics) are one of the most profound effects of these kids' experiences. These roles were first described by Sharon Wegscheider-Cruse and referred to children from alcoholic families. As with all of the characteristics, they also exist with other dysfunctions. The key to these roles is that the individual generally feels one way and acts another. The inner circle on each diagram represents the feelings and the outer corresponds to the outward behavior.

Chief Enabler:

This role is most frequently taken on by the spouse although each of the roles serves an enabling purpose. This person protects the dysfunctional family member from the natural consequences of their behavior. Their primary focus is on trying to make things right, trying to cover up and maintain

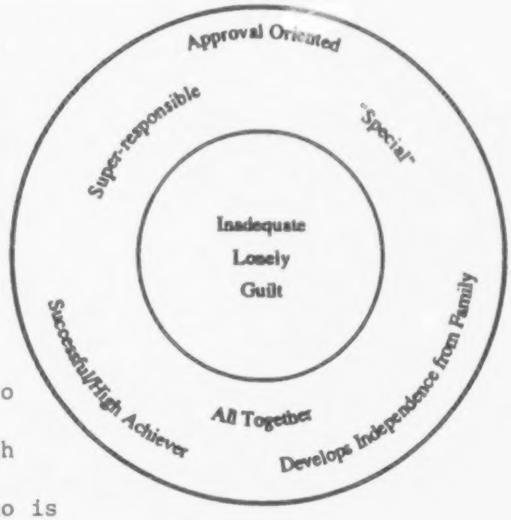


In the Classroom:
Makes excuses and performs tasks (e.g., assignments, etc.) for the chemically dependent friend or sibling.

the family's "No Talk" rule, trying to keep all stress away from the dysfunctional individual, and anything else that is needed to make things easier. Typically, the motivation for this behavior is a combination of care and concern with guilt, frustration and anger. The enabler often feels at least somewhat responsible for the dysfunction in the family and tries to make it all better. To make up for this guilt, they will attempt to be responsible for everyone and everything in the family (paying bills, attending school conferences, making excuses, and monitoring everyone's adherence to the family rules). Although the enabler holds the family together, they do so at great cost to themselves (emotionally and, sometimes, physically) and to the children in the family. The enabler's primary focus is on the dysfunction, which means that often the children in the family do not receive sufficient attention and nurturing. Thus, many of the kid's roles and the damage done by living in a dysfunctional family stems from the enabler as well as from the actual dysfunction.

Hero or Caretaker:

This role provides a sense of self-worth for the family. This is the child who is feeling inadequate and lonely and attempts to gain attention by being "super-kid". The hero is usually a very high achiever in school who is also active in extra-curricular activities as well as helping out at home (the enabler's "right



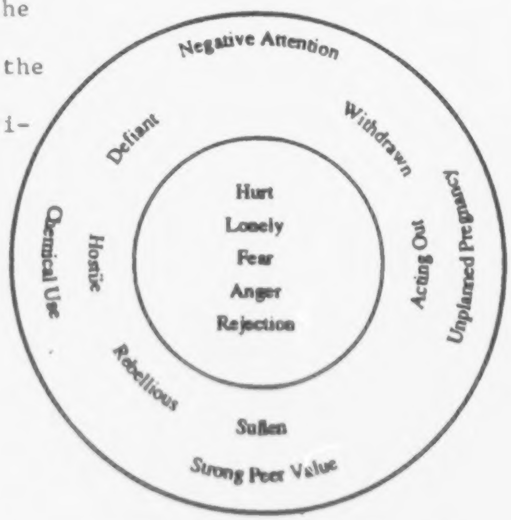
In the Classroom:
High achiever, "teacher's pet," always volunteering, doing more than expected, bossy.

In Adult Life without Intervention:
A workaholic, fosters dependencies, may marry an alcoholic/addict.

In Adult Life with Treatment:
An excellent executive. Can acknowledge own limitations.

hand"). They seem to have everything all together and are exactly the type of child every teacher dreams of having in their classroom. What no one sees, however, is that this child suffers from low self-esteem, loneliness and guilt. Nothing they ever do is good enough (since they are trying for perfection) and all of their feelings of worth are external rather than being internalized. They also tend to appear mature beyond their years and take everything very seriously. Most heros do not know how to relax and have fun.

Scapegoat:



In the Classroom:
Usually in public eye, gets negative attention, anti-social behavior/rule breaker, disrupts class, doesn't hand in work.

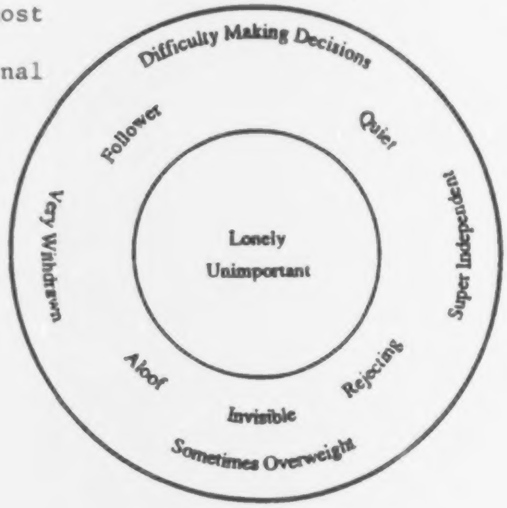
In Adult Life without Intervention:
Trouble maker at work, may go to prison.

In Adult Life with Treatment:
Good survivor, courageous/assertive, sensitive counselors.

This role is actually the most congruent of the bunch since one of the feelings they experience is anger and this is exactly what the world sees. However, they also feel lonely, scared, hurt, and rejected and these feelings they keep to themselves. The scapegoat provides a crucial function for the family in that they are the one everyone can point to and say "that's our problem". These are the children who drive teachers (and everyone else around them) crazy with their acting out. This acting out is, in fact, a way to get attention. Since the role of hero may already be filled, they feel they have to behave in an opposite way to be noticed. This does give them attention, but since it is in the form of negative attention, they end up feeling even more hurt, lonely, scared, and rejected. Since they don't know how to deal with these feelings, they will tend to convert them into anger and act out more.

Lost Child:

This child often ends up with some of the most devastating emotional scars of all the children. Their function in the family is to provide relief from stress. To do this they work very hard at not being noticed and not causing any trouble. They never stand out in any way and tend to withdraw from anything that might be a problem. This behavior is reinforced by a family that has no energy to deal with demands. And the lost child makes none. Although they tend to do well in school, it is never good enough to be singled out. They will often go an entire year without anyone really paying much attention to them one way or another. For this reason, they are a very high risk for suicide (no one will miss me). Interestingly, they also tend to be very creative. Since they don't like the world they have, they create their own. While they spend time alone they fantasize about what their life would be like if mom or dad didn't drink. They write, paint, and listen to music, but never share this side of themselves with anyone.



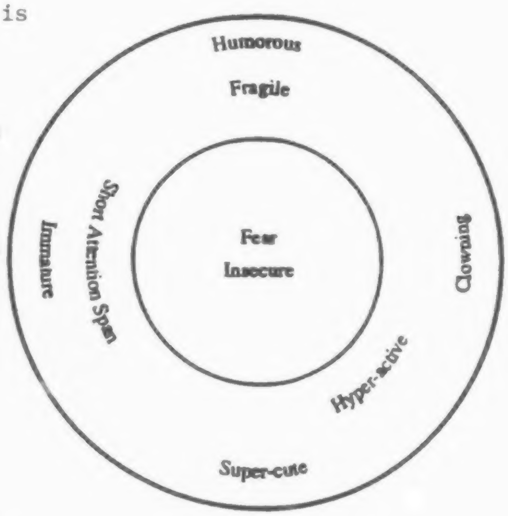
In the Classroom:
Escapes by physical or emotional disconnection. Is a loner, has a rich fantasy life, is apathetic and does not attract attention.

In Adult Life without Intervention:
Is low energy/lacks spark, is sexually promiscuous, and may have sexual identity problems.

In Adult Life with Treatment:
Is creative, artistic, imaginative, talented, and independent.

Mascot:

As with the scapegoat, the role of the mascot is designed to pull attention away from the dysfunction. However, this child achieves that diversion by being super-funny and playful. They create a false sense of fun and well-being for the family. The crazier and more stressful things become in the family, the more humorous they become. This role can best be described by the title to the song "Tears of a Clown". While we see the fun and humor, they feel the sadness, fear, and loneliness. They make people around them feel good at the expense of their own feelings. Although they seem to be able to laugh everything off, they are actually very sensitive and take things very personally.



In the Classroom:
Acting out in a cute way, never serious.

In Adult Life without Intervention:
Compulsive clown, immature, can't handle stress/ulcers, needs to be taken care of.

In Adult Life with Treatment:
Good sense of humor, fun/playful, can take care of self.

Each of the roles in a dysfunctional family serves a purpose. For the individual, the role is an attempt to deal with the underlying, painful feeling. For the family, each role helps the family survive by providing things such as self-worth, relief, and a focus of attention. We can look at each role using the following chart adapted from "Co-dependency: An Emerging Illness Among Professionals" by C.L. Whitfield:

System Dynamics of the Dysfunctional Family*

Role	Motivating Feeling	Identifying Symptoms	Payoff For Individual	Payoff For Family	Possible Price
Dependent	Shame	Chemical use	Relief of pain	None	Addiction
Enabler	Anger	Powerlessness	Importance; Self-righteous	Responsibility	Illness: "martyrdom"
Hero	Inadequacy; guilt	Over-achievement	Attention (positive)	Self-worth	Compulsive drive
Scapegoat	Hurt	Delinquency	Attention (negative)	Focus away from dependent	Self-destruction addiction
Lost Child	Loneliness	Solitariness; shyness	Escape	Relief	Social isolation
Mascot	Fear	Clowning; hyperactivity	Attention (amused)	Fun	Immaturity; emotional illness

*Adapted from "Co-dependency — An Emerging Illness Among Professionals" by C.L. Whitfield.

Many of you may have looked at these roles and said: "Don't all kids exhibit these characteristics to a curtain extent? Often based on birth order?" The answer is "Yes, they do. The issue becomes the degree to which they become stuck in these roles." Just as families exist on a continuum, so the roles exist on the same continuum. The more dysfunctional the family, the more stuck and rigid a child will be in their role. The key is that rather than being a tendency, these kids exhibit these behaviors in order to survive. They don't know any other coping skills. Another issue is the incongruity. Their insides don't match their outsides. So, in looking at whether kids fit these characteristics or not, we look for degree of rigidity and congruity.

There are other signs we can look for in children, particularly in those who come from alcoholic families. These were outlined in a book entitled "Broken Bottles, Broken Dreams" by Charles Deutch. The following lists of behaviors may (note the word "may") be indicative of children growing up in a chemically dependent home.

General Indications:

* Morning tardiness (especially Monday mornings)
* Consistent concern with getting home promptly at the end of a day or activity period.
* Malodorousness.
* Improper clothing for the weather.
* Regression: thumbsucking, enuresis, infantile behavior with peers.
* Scrupulous avoidance of arguments and conflict.
* Friendlessness and isolation.
* Poor attendance.
* Frequent illness and need to visit nurse, especially for stomach complaints.
* Fatigue and listlessness.
* Hyperactivity and inability to concentrate.
* Sudden temper and other emotional outbursts.
* Exaggerated concern with achievement and satisfying authority in children who are already at the head of the class.
* Extreme fear about situations involving contact with parents.

Indications During Alcohol Education:

* Extreme negativism about alcohol and drinking.
* Inability to think of healthy, integrative reasons and styles of drinking.
* Equation of drinking with getting drunk.
* Greater familiarity with different kinds of drinks than peers.

- Inordinate attention to alcohol in situations in which it is marginal, for example, in a play or movie not about drinking.
- Normally passive child or distracting child becomes active or focused during alcohol discussions.
- Changes in attendance patterns during alcohol education activities.
- Frequent requests to leave the room.
- Lingering after activity to ask innocent question or simply to gather belongings.
- Mention of parent's drinking to excess on occasion.
- Mention of drinking problem of friend's parent, uncle, or aunt.
- Strong negative feelings about alcoholics.
- Evident concern with whether alcoholism can be inherited.

Once a pattern of the role behaviors or classroom indicators are noticed it is important to reach out to the child to try to get them help. This is difficult, because of the "No Talk" and "No Trust" rules that the family has imposed. It is not impossible, however, and needs to be attempted given the long range damage that can occur.

Help for the Child of a Dysfunctional Family:

> You say, "How can a teacher or guidance counselor make a difference when everything in the kid's world reinforces the messages of shame and guilt?" But I think it's like listening to a symphony. There may be an overwhelming amount of sound, but if the person sitting behind you is tapping his foot out of rhythm, you hear it. Even though it's one little voice, it's so dissonant with the message you've always heard that it takes on an importance. One voice speaking when your whole world is shouting something different, it can really make a difference. Especially if what that voice is saying is something it feels good to hear.
>
> -Charles Deutsch-

Most of the help that a child living in a dysfunctional family needs will come from outside of the school setting. Many will need therapy or involvement in a 12-step program such as Alateen. However, school is also an ideal place to identify and reach these children. Many schools are beginning to establish weekly support groups for children living in chemically dependent homes. In other cases, school counselors may work with the child to try to break through the "No Talk" and "No Trust" rules and help them to deal with their feelings. Teachers can also play an influential role in these kids lives.

Although teachers will not (and should not be expected to) do therapy with children living in a dysfunctional home, there are many things that can be done. For each of the family roles described earlier there are some very specific do's and don't's that teachers can follow:

Hero

Do:

1. Pay attention at times when they are not achieving.
2. Validate them as a person separate from their accomplishments.
3. Teach them that it's OK to make a mistake and learn from them.
4. Teach them how to have fun.

Don't:

1. Let them monopolize the class and answer all the questions.
2. Validate their worth as a person through achievement.

Primary Feeling:

Inadequacy

Scapegoat

Do:

1. "Catch them being good." Pay attention to them when they are not acting out.
2. Set clear limits and follow through on consequences consistently.
3. Give them chances to be responsible and then validate any and all success.
4. Find out what they enjoy and are good at and give them a chance to be helpful to you.

Don't:

1. Get hooked by the anger and react defensively.
2. Take the child's behavior personally.
3. Overlook acting out behavior no matter how frustrated you may get.

Primary Feeling:

Hurt, Guilt

Lost Child

Do:

1. Call the child by name and establish eye contact.
2. Be aware of creativity and encourage those pursuits.
3. Make a personal connection with the child.
4. Have them work in small groups with other students.
5. Use touch slowly.

Don't:

1. Let them off the hook - insist that they answer even if it is brief.
2. Let other children speak for them.

Primary Feeling:

Unimportance, Loneliness

Mascot

Do:

1. Try to give them a job in the class that they can accomplish.
2. Provide times when it is OK to be funny.
3. Set clear boundaries and follow through on consequences consistently.
4. Hold them accountable.

Don't:

1. Laugh at their behavior.
2. Allow them to dominate the class.

Primary Feeling:

Fear, Insecurity

Keeping these simple tools in mind can help these children immensely. For all of them, one of the best things a teacher can do is to make the classroom a safe, caring, non-judgmental and consistent place to be. These are all of the things they don't get at home.

Finally, all of these children need to learn to accept several important facts:

1. They didn't cause the family problems or parental drinking or drug use.
2. They can't make it go away.
3. They can learn to respond differently to what happens at home.
4. They are worthwhile, loveable people

As they accept these things, they can start to feel better about themselves and can ultimately avoid many of the typical "adult children of dysfunction family" characteristics. Remember always that you can make a difference in the lives of these young people.

This song can be used to discuss the "No Talk" rule of the dysfunctional family.

CODE OF SILENCE

Everybody's got a million questions
Everybody wants to know the score
What you went through
Is something you should be over now.

Everybody wants to hear the secrets
That you never told a soul before
And it's not that strange
Because it wouldn't change
What happened anyhow

But you swore to yourself a long time ago
There were some things that people never needed to know
This is one that you keep
That you bury so deep
No one can tear it out

And you can't talk about it
Because you're following a code of silence
You're never gonna lose the anger
You just deal with it a different way

And you can't talk about it
And isn't that a kind of madness
To be living by a code of silence
When you've really got alot to say

You don't want to lose a friendship
There's nothing that you have to hide
And a little dirt
Couldn't hurt no one anyway

And you still have a rage inside you
That you carry with a certain pride
In the only part of a broken heart
That you could ever save

But you've been through it once
You know how it ends
You don't see the point
Of going through it again
And this ain't the place
And this ain't the time
And neither's any other day

So you can't talk about it
Because you're following a code of silence
You're never gonna lose the anger
You just deal with it a different way

So you can't talk about it
And isn't that a kind of madness
To be living by a code of silence
When you've really got alot to say

I know you well enough to tell you've got your reasons
That's not the kind of code you're inclined to break
Some things unknown are best left alone forever
And if a vow is what it takes
Haven't you paid for your mistakes

After the moment passes
And the impulse disappears
You can still hold back
Because you don't crack very easily

It's a time honored resolution
Because the danger is always near
It's with you now
But that ain't the way it was supposed to be

And it's hard to believe after all these years
That it still gives you pain and it still brings you tears
And you feel like a fool
Because in spite of your rules
You've got a memory

But you can't talk about it
Because you're following a code of silence
You're never gonna lose the anger
You just deal with it a different way

But you can't talk about it
And isn't that a kind of madness
To be living by a code of silence
When you've really got alot to say

Written by: Billy Joel
From: The Bridge

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ENABLING

Please don't spoil everything
by telling me the truth.
-Ashleigh Brilliant-

The concept of enabling is a very important one with respect to high risk students. The dictionary defines it as a positive term meaning "to empower, to give power to, to allow or permit, to make possible or easy". We talk about "enabling a student to reach their full potential" or someone's hard work "enabling them to reach their goal". All of these are very accurate uses of the term, but are very different from the way it is used when talking about high risk behaviors.

In effect, enabling is anything that we do that encourages a behavior to continue and/or increase. This is fine when we are talking about reaching one's goals or getting good grades. When talking about behaviors such as drug use, suicidal ideation or attempts, truancy, delinquency, and other high risk behaviors, then enabling is not such a positive concept. When we enable high risk behaviors we encourage them to continue or increase which is not something that most people would choose to do. It, therefore, becomes important to look at how people enable kids to continue their high risk behavior and what can be done to change this process to one which empowers them to make positive choices.

In defining the negative enabling that exists with high risk behaviors we can state that it is:

> "Any behavior or attitude which unwittingly assists in minimizing or removing the consequences of high risk behavior, thus allowing or encouraging the behavior to continue or increase."

The primary components of this definition are that: 1) it consists of a combination of behaviors and attitudes; 2) it is generally done unwittingly; 3) it functions by removing the natural consequences of one's behaviors; and 4) the end result is that the high risk behavior continues and often increases. It is also important to note that enabling can be done by one person or many. In the case of many, we can talk about an entire system enabling.

As was mentioned in the definition, enabling can be made up of behaviors or attitudes. Often it is a combination of the two. The beliefs or attitudes we hold influence our behavior. The attitudes most commonly associated with high risk behaviors, such as addiction, have to do with how we perceive people with those behaviors. Our behaviors can take the form of acts of commission (such as bailing a person out of jail) or acts of omission (such as overlooking certain behaviors). Either way, the end result is that the individual does not experience the consequences of their behavior, thus allowing it to continue.

The definition of high risk enabling states that it is generally unwitting. Most people do not set out to intentionally harm another person. Enabling happens unconsciously and usually out of the best of intentions. This cannot be stressed enough. Most people, when they realize they have been enabling kids, feel very guilty. Remember that "you did the best you could with what you knew." Even becoming aware of enabling does not guarantee that a person will not enable again. We are not perfect.

One of the reasons that we have all been enablers and will continue to do so, to a certain extent, even after learning about it has to do with the motivations behind enabling behaviors and attitudes. The primary motivating factors are:

1) **Care and Concern:** When someone we care about is hurt, in trouble, or in emotional pain, our first response is to want to make it better. We want to take care of them, comfort them, and make all the pain go away. We get very protective. This is fine in the case of someone who has the flu or who has suffered a loss. Generally they will gradually get over it on their own, and our care and concern can make things a little more tolerable in the meantime. With high risk behaviors, this care and concern backfires and ends up encouraging the very behaviors we want to discourage. The spouse who protects the alcoholic from stress so he/she "won't drink as much" actually makes things easier for him/her to continue to drink.

2) **Attempts to Help:** Similar (or connected) to care and concern is our genuine desire to help. This is a very strong motivating factor for people in the fields of education and counseling since the desire to help is why most people enter those fields. The problem is that there is a difference between healthy helping and unhealthy helping. Healthy helping assists the person in learning skills which allow them to take responsibility for themselves. Unhealthy helping teaches people to be dependent on someone else to solve their problems. It comes down to the old saying:

> "If you give a man a fish,
> you feed him for a day.
> If you teach a man to fish,
> You feed him for a lifetime."

Although it may be easier to just hand him the fish, in the long run he learns more if he is forced to do it himself.

3) **Fear:** Often people are motivated to enable by fear. Fear of what people will think and how they will judge us if they find out how this child is acting. Will they think I'm a bad parent or teacher? Will they blame me as the administrator if they find out how much drug use exists in the school? To avoid this fear, we cover up the behavior so that no one has to know that we have failed.

4) **Ostrich:** "If I can't see it, it doesn't exist." This is the ostrich technique. It is the easy way out. If a problem is not acknowledged then nothing needs to be done to solve it. We may also think that if we ignore it, the problem will disappear on its own. "Maybe it's just a stage they are going through and if we wait, it will get better by itself." Unfortunately, while this may happen with some things, it usually does not with high risk behaviors.

5) **Lack of Information, Knowledge or Skills:** Often enabling occurs because the person just doesn't know what else to do. Unfortunately, our society tends to reinforce enabling behaviors by urging people to help without clarifying when and how we should do so. We get frustrated because nothing seems to help the person change. We talk to them, we plead and beg, we give them extra chances, we overlook behavior and we just can't understand why it keeps getting worse. It would be ideal if everyone going into one of the "helping" professions (including education) could learn about enabling and learn ways to "empower" rather than "enable". This may eventually happen, but for now people will just have to continue doing the best they can with what they know.

6. **Denial and Vulnerability to Manipulation:** This ties back into care and concern. If I care about someone, I want to believe the best of them. I will have a tendency to deny the dysfunctional behaviors that a stranger can notice quickly. I will also be more apt to buy into their statements of "I'm sorry, I promise it won't happen again. Please give me one more chance." So the high risk kid gets chance after chance because people around them care and want to help. It becomes a twisted, dysfunctional system that involves both people (the high risk kid and the enabler) and requires actions by both to keep going.

Obviously, each individual will have their own motivating factors, but this gives an idea of some of the more common.

Enabling in the School Setting

Now that we have defined enabling with respect to high risk behaviors and identified some of the motivating factors, we need to examine more specifically the ways in which educators enable students. There are a number of behaviors and attitudes exhibited by classroom teachers, counselors and other pupil services staff, and administrators which can be labeled "enabling". There are also ways in which the system as a whole enables high risk students to continue their behavior. Remember that all of these are unconscious and generally not motivated by any intent to harm.

Classroom Teachers:

Students spend the majority of their time in the school setting in the company of classroom teachers. For this reason, teachers have numerous opportunities to enable students' high risk behavior. For the most part, these enabling behaviors take the form of acts of omission such as failing to recognize and/or report students' high risk behavior (particularly alcohol or other drug involvement). More specific behaviors reported by classroom teachers include (from: Enabling in the School Setting by Gary Anderson):

1. Avoiding places in the school building or on its grounds whe students are known to use alcohol/drugs.
2. Failing to recognize, confront, or report apparent exchanges of money and/or drugs in such areas as classrooms, halls, or cafeteria.
3. Ignoring unacceptable behavior in the classroom.
4. Ignoring apparent intoxication of students in the classroom or other areas of supervision.
5. Ignoring or supporting students' verbal announcements in class about alcohol/drug use.
6. Having unclear or inconsistent standards of acceptable academic performance and classroom conduct.
7. Failing to report incidents of observed student alcohol/drug use to those designated to handle such issues.
8. Failing to refer students suspected of alcohol/drug involvement, or who have a pattern of unacceptable performance or conduct, to those designated to handle such problems.
9. Attempting to affect the alcohol/drug-related behavior of individual students by "counseling" them oneself.
10. Believing, without investigating, that a given student couldn't possibly be alcohol/drug-involved because he or she gets good grades, is an athlete, is a "good kid".

Pupil Services Workers:

Most people would tend to think of counselors, social workers, psychologists, nurses, and other pupil services workers as people who are trained to help and, therefore, who would not enable. Unfortunately, this is not true. As a matter of fact, most people in these positions agree that some of their training actually encourages them to enable by stressing helping without clarifying healthy vs. unhealthy helping. People in these positions are as susceptible to enabling as others. Some of the ways in which this occurs include (from: Enabling in the School Setting by Gary Anderson):

1. Making judgements or decisions or taking action despite lack of formal training in alcohol/drug concepts and skill.
2. Failing to include questions about alcohol/drug use as a routine part of counseling sessions with troubled or problem students.
3. Regarding certain kinds of student alcohol/drug use as acceptable (i.e., to be condoned rather than merely expected).
4. Believing, prior to investigation, that a given student couldn't possibly have an alcohol/drug problem, or that chemical use has no role in a student's problems.
5. Attempting to deal with students' alcohol/drug behavior by oneself.
6. Failing to involve other authorities in dealing with the alcohol/drug-involved student.
7. Failing to refer to community alcohol/drug counseling agencies those students who don't respond to in-school services.

Administrators:

The enabling behaviors of administrators tend to revolve around two primary issues. The first has to do with their role as disciplinarian and how they enforce policies. The second has to do with support for the people who deal with students who are experiencing alcohol/drug problems. The specific behaviors reported by administrators that fall into the realm of enabling include (from: Enabling in the School Setting by Gary Anderson):

1. Taking action despite lacking formal training in alcohol/drug issues, especially in school-related issues.
2. Taking disciplinary action without consulting or involving other school or helping professionals.
3. Taking disciplinary action without knowing the degree of a student's alcohol/drug involvement.
4. Taking disciplinary action merely to punish rather than to provide students with choices that involve addressing their unacceptable alcohol/drug-related behavior.
5. Failing to take disciplinary action on alcohol/drug problems for fear of parent or community reaction or fear of lacking the support of other administrators.
6. Failing to admit openly or deal with alcohol/drug problems in the school to protect one's position or the school's image.
7. Believing that "cleaning up" alcohol/drug problems is really the responsibility of counselors, the police, or parents.
8. Failing to support the recommendations of counselors and teachers regarding how to handle students with alcohol/drug-related problems.
9. Believing in simplistic responses to the "alcohol/drug problem"

(e.g., supposedly ridding the school of alcohol/drug by renting police dogs to sniff lockers, relying on scare tactics or lectures by alcohol/drug experts).

10. Enforcing a "get-tough" policy that doesn't include provisions for assessment, education, counseling, or referral.

Other Personnel:

There are many other people within the school setting who enable in specific ways. Attendance clerks who "overlook" the different handwriting on excuse notices because "he/she is such a sweet kid". Coaches and athletic directors who fail to report suspected alcohol or other drug use by their star athlete. Cafeteria workers who don't say anything when they overhear kids in the lunch line talking about how drunk they got last night. Bus drivers who ignore disruptive behavior because it's easier and "besides, I'm only one person with no back-up on this bus full of kids". All of these people enable kids to continue their high risk behavior. The motivations and specific behaviors vary. The end result is the same and is detrimental.

System Enabling:

Just as individuals can enable students, often the entire system becomes enabling. This enabling generally occurs in three areas within the system; 1) policies and procedures, 2) responsibility, and 3) support. The system can often frustrate the individual school staff who attempt to avoid their own enabling behaviors by preventing them from being successful.

School policies and procedures are one of the most common ways in which school systems enable. A school that does not have clear alcohol and other drug use policies will create a system where individuals are powerless to handle situations that arise and, therefore, may choose to ignore problem behaviors. Even schools that do have clear policies run into problems. Enabling occurs if policies are not followed consistently, are too narrow in focus (such as focusing only on intoxication but not possession), are too punitive causing people to avoid having to enforce them (which allows kids to avoid the consequences of their behavior), or have vague consequences for behavior. All of these factors in policy development need to be considered by school systems who wish to reduce enabling behavior. Schools also need to consider having some form of policy for staff so that there is no double standard. Many schools are instituting Employee Assistance Programs as they develop Student Assistance Programs.

The issue of responsibility also sets up system-wide enabling. Unless there is a specific process outlined which designates the person or people responsible for dealing with high risk behaviors, it is likely that nothing will get done. Everyone will assume (or hope) that it is someone else's job and the child is allowed to continue their dysfunctional behavior. When schools set up an SAP referral process (discussed in more detail later), everyone needs to clearly understand this process, including who will be responsible for coordination and how to get help for a kid in trouble. The flip side of this is to make sure that responsibility doesn't become a turf issue with people trying to "hold on" to what they feel is "theirs". If this happens, discussions can arise about whether it is a "counseling" issue or a "discipline" issue, when in fact it may be a little of both.

This generally leads to the third concern with system enabling which involves support. Dealing effectively with high risk students is not something that can be done by one person. There needs to be a combined effort by a multi-disciplinary team. This also means that people on the team (as well as those utilizing the expertise of the team) need to be able to count on each other. If I do something to start the process, I need to know that the others involved will do their part. It is also important to know that the whole process is being supported by the system (teachers, counselors, administrators, school board, and parents). Often, lack of this kind of support is what can set up enabling both on a system and individual basis.

Empowering

If we are using "enabling" as a negative term, we need one to refer to the positive behaviors we want to encourage. For this we will use "empowering" and will define it as follows:

> "Conscious behaviors by individuals and the system as a whole which require students to experience the natural and logical consequences of their high risk behavior and/or prevent further high risk behavior."

Note the use of the word "conscious". If enabling is unwitting, empowering has to be purposeful. It involves conscious implementation of policies and procedures by the system and individuals that hold kids accountable. Following through on policy, confronting behavior, referring for assistance if needed, etc. Empowering also involves prevention activities conducted to keep other kids from getting involved in high risk behaviors. This could include substance abuse curriculum, alternative leisure activities, or parent education programs. In essence, empowering involves implementation of a comprehensive Student Assistance Program (discussed later).

There are several factors which are necessary in order for this to happen. The first is education of the entire staff about enabling. People need to be given an opportunity to learn how they may be unknowingly allowing kids to get further into trouble. This is often enough for people to begin to change to a more empowering frame of reference. The second thing that needs to happen is that a clear and consistent process must be established for dealing with high risk kids with support provided from all levels of the system. And finally, people within the system need to be willing to let go of preconceived ideas and beliefs about kids, substance abuse and other high risk issues, and how best to deal with them. This is often the hardest. We all have beliefs and attitudes (many of which come from our own personal experiences) that can get in the way of empowerment. We will need to take a good hard look at those beliefs and be willing to change in the face of new evidence.

ENABLING BEHAVIOR INVENTORY

Below are a list of characteristics which represent the beliefs, feelings and behaviors involved in professional enabling. For each question, indicate the degree to which it applies to your involvement with possible alcohol and other drug abuse in your students.

	YES	NO	SOMETIMES
1. Do I overlook obvious problems?	____	____	____
2. Do I oversimplify problems related to alcohol or other drug abuse?	____	____	____
3. Do I view chemical dependency as primarily a moral issue?	____	____	____
4. Do I tend to "gossip" in the staff lounge about the alcohol/drug problems of students?	____	____	____
5. Do I typically think of a person with an alcohol/drug problem as "one of those people?"	____	____	____
6. Do I avoid confronting unacceptable behavior?	____	____	____
7. Do I accept too many excuses?	____	____	____
8. Do I feel uneasy, tense or anxious after handling a situation involving alcohol/drug abuse?	____	____	____
9. Do I lack clear and consistent guidelines for student behavior?	____	____	____
10. Am I ever so frustrated that I ignore a student's need?	____	____	____
11. Am I uncomfortable bringing up the subject alcohol or other drug use when working with a student?	____	____	____
12. Do I avoid reporting observed or suspected instances of student alcohol/drug use?	____	____	____
13. Do I avoid dealing with a child because of my apprehensions about facing the parents?	____	____	____

	YES	**NO**	**SOMETIMES**
14. Do I attempt to handle problems of student alcohol/drug use without any help from others?	___	___	___
15. Do I focus on disruptive behavior at the expense of the other students?	___	___	___
16. Do I ignore or condone student references to drinking or drug use?	___	___	___
17. Do I fail to set a healthy example for students with respect to my own use of alcohol and other drugs?	___	___	___
18. Do I protect a student from the consequences of their behavior by minimizing the seriousness of the problem?	___	___	___
19. Do I deny the extent of substance abuse in the school and community?	___	___	___
20. Am I overly concerned that students will like me?	___	___	___
21. Do I try to avoid those about whom I am worried?	___	___	___
22. Do I regard some degree of student alcohol/drug use as expected or acceptable?	___	___	___
23. Do I make excuses for, cover-up, and defend student drug use or other unacceptable behavior?	___	___	___
24. Do I sometimes compromise my own values or beliefs?	___	___	___
25. Do I maintain the "no talk" rule concerning alcohol/drug problems in students and their families?	___	___	___
26. Do I believe that students could stop using alcohol/drugs on their own if they wanted to?	___	___	___
27. Do I minimize or excuse student alcohol and other drug use?	___	___	___
28. Do I believe that there is no reason for the school to be involved in solving alcohol/drug problems?	___	___	___

Adapted from questionnaires by Gary Anderson and Emily Garfield.

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CORE TEAM DEVELOPMENT

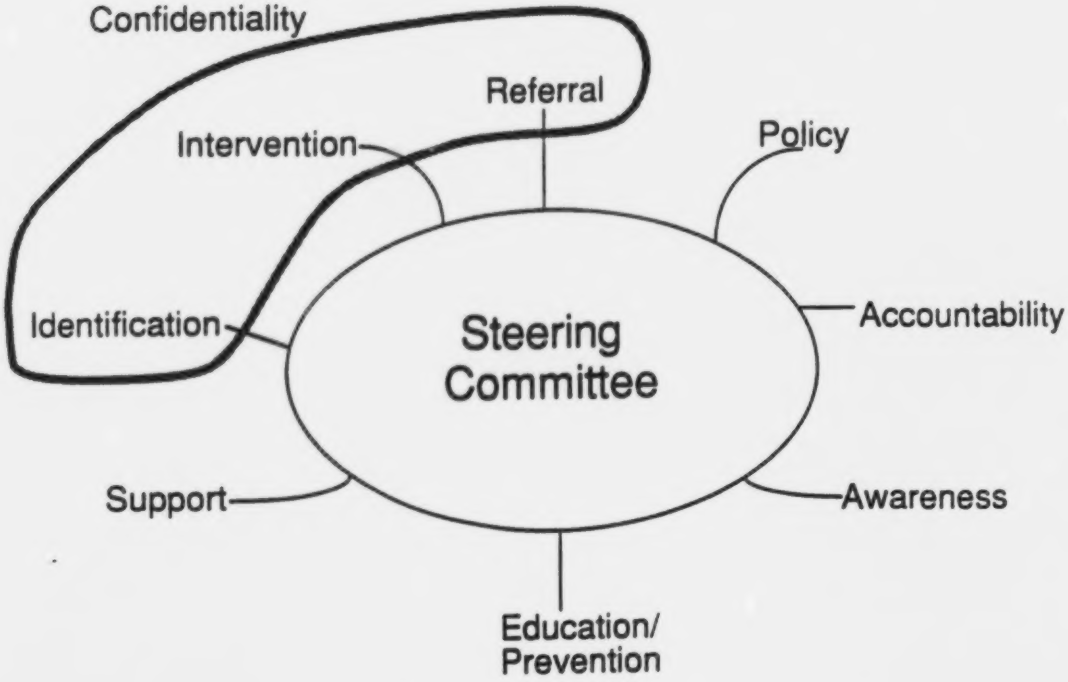
If you want one year of prosperity - grow grain.
If you want ten years of prosperity - grow trees.
If you want one hundred years of prosperity - grow people.
-Chinese Proverb-

In the face of all of the issues facing the student of the 90's, growing effective, successful, healthy people is becoming much more difficult. To accomplish this task it will take more than one person's energy. It will take the combined energy of a team. Any time there has been a significant change in our society, it has involved the work of a group. Although we tend to idealize and recognize the efforts of the individual hero, the reality is that a group is far more successful at creating change. Those individuals who have been instrumental in initiating change, could not have done so without some sort of group to support their actions. Therefore, when we look at creating a Student Assistance Program, we need to take a team approach.

A "Core Team" can be defined as a multi-disciplinary team of people from the school and community, who meet on a regular basis to design, implement and evaluate a comprehensive Student Assistance Program (SAP). This program will have as its focus the creation of a supportive school/community environment which promotes wellness in all children. It's members include school personnel (administrators, counselors, teachers, nurses, secretaries, custodians) as well as community members (parents, clergy, law enforcement, mental health workers). Having students involved is also very beneficial. The specific components of the program (which will be discussed in more detail later) are divided into three specific areas and include:

Administrative	Kid-Centered	Intervention
Policy - consequences - assistance	Awareness ← student use surveys (parent ed.) - staff	Identification (rather than diagnosis)
Accountability	Education/Prevention	Intervention
	Support	Referral (for ASSESSMENT NOT treatment)

Each team member will most likely work on one area of concern depending on their role and interests. The only requirement is that the Intervention activities be done solely by school personnel due to issue of confidentiality. Typically the design of the Core Team will be to have a coordinating steering committee and smaller committees to work on each of the tasks. This design might look something like this:



Regardless of whether the team looks like the above or not, the crucial thing is to meet on a regular basis. Even if the meetings only last 15-20 minutes during lunch, it is at least a functioning team. Schools have tried other structures from handing the program over to a single person to having individual autonomous committees. If this is the case, and it is working, there is no reason to change things. However, the overall experience of SAPs has been that the team approach works best and that communication between committees is crucial.

In order to effectively build this team and develop a comprehensive Student Assistance Program, training for team members is crucial. There are many ways to conduct this training and numerous companies and agencies providing it, but most are done using an intensive week-long training followed by inservice sessions. The initial training will generally cover topics such as identifying high risk students, dysfunctional families and their effects on children, enabling in the school setting, intervention skills, the components of a Student Assistance Program, and Core Team development and planning. Other topics may be included depending upon the needs of the area and the expertise of the trainer. In chosing a training program, the more comprehensive the focus the better. Trainings that focus solely on intervention without discussing prevention and support issues will only give a piece of the puzzle. After the initial training, inservice sessions can be provided on an ongoing basis to further refine skills, increase knowledge in particular areas, and iron out any difficulties.

Obviously, to design and implement a team and program that is comprehensive will take time. The typical length of time is anywhere from two to three years. Success cannot be rushed. It also needs to be developed carefully. Throughout the creation of a Core Team and comprehensive Student Assistance Program, there are several common pitfalls that reduce the effectiveness of the team and often lead to frustration and burn-out. Three specific traps appear to be most prevalent, and are relatively easy to avoid.

"Witch Hunt" - This occurs when teams spend all of their time and energy on interventions, and no time on prevention, education, support, etc. This is easy to do at first, since the kids that need help are so obvious. Unfortunately, many teams get stuck here and never develop other programs. The danger comes in two areas:

1. The students, staff, and parents get the idea that the team is some sort of hit squad and retreat even further into denial and enabling.
2. The focus is entirely on problem behaviors and the negative, so that the team experiences burn-out.

To avoid this, remember that SAPs work best when they are comprehensive and work with all students, not just the extremely high risk ones.

"Secret Society" - This trap occurs when the team exists, but no one in the school or community quite knows what it does. This becomes problematic because there may be an excellent process for helping high risk kids, but if no one knows what to do, it becomes useless. In addition, people will sabotage those things from which they are excluded. If other staff don't feel that they can become a part of the process, they will undermine the effectiveness of the team. Finally, this also leads to the image of a hit squad functioning in secret. While the names of individuals referred need to be kept confidential, it is important that the entire staff, student body, and community know what the Core Team is and what it does and are invited to join in the process.

"Turf Wars" - This trap happens when any group (teachers counselors, administrators, parents) sees the team as trying to "take over" their job. That group will then become more territorial and will sabotage the well-intentioned efforts of the team. When presenting a new program to any group, remember to explain it in an inclusive manner rather than an exclusive one. Stress the word and concept "we" in as many ways as possible and outline how it will make individual jobs easier. Focus on the team concept and the need for everyone to work together. Finally, avoid going to a particular group and saying "this is the problem" without offering a solution and a way that you can assist.

Obviously, these are not the only traps, but they are some of the most common. They happen out of the best of intentions (to help high risk kids get help, to maintain confidentiality, and to design a new program), but can backfire if not handled carefully. By concentrating on having a comprehensive program that is open in its communication and includes people from every discipline (staff, students, and community) a Core Team has a much better chance of success and growth. And that, after all, is the goal of the program.

TEAM BUILDING

I prefer group activity because, even if it's foolish,
at least I'm not the only fool.
-Ashleigh Brilliant-

Since the Core Team is the primary energy source for a comprehensive Student Assistance Program, it is important to address the issue of how it develops. By examining the stages of development for the team as well as those factors that help or hinder its growth we can facilitate the process and ensure a healthy team. Regardless of how a school structures the Core Team, all teams will go through predictable stages. And there are definite characteristics of healthy teams and healthy team members as well as factors that will encourage their existence.

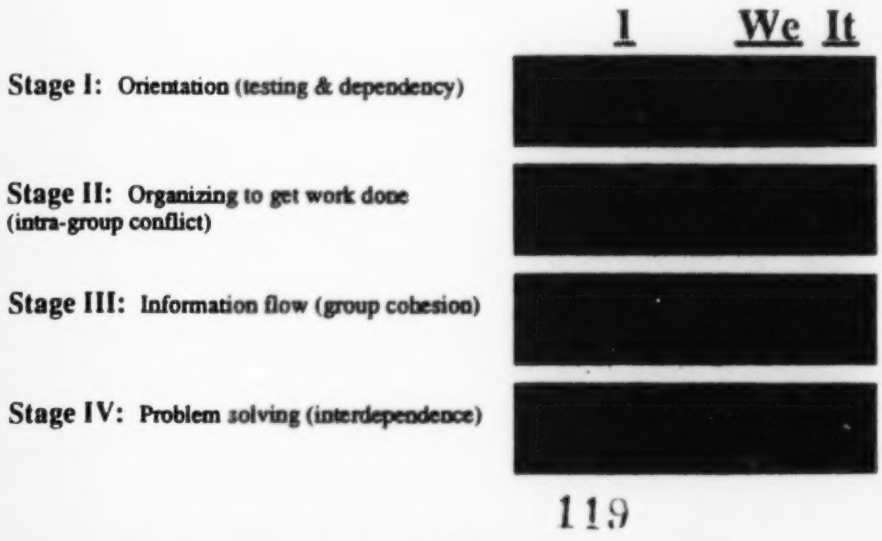
The first thing to address are the different levels of functioning for each team. When any group of people work together as a team there are three types of needs which exist simultaneously. These needs are:

* **I-Needs:** The needs of the individual members. This includes getting oriented to the group and determining whether one's own needs will be met.
* **We-Needs:** These are the needs of the group and involve the actual group process and functioning. Some of these needs involve membership roles, ground rules, leadership, and group structure.
* **It-Needs:** These are the needs stipulated by the group task. This involves the goals, objectives, and activities needed to meet the task needs of the group. Also included is the group's relationship to people outside of its membership and any possible roadblocks.

The successful team is the one that can deal effectively with needs at all three levels.

There are several variables which will determine how well the team works at each level. The first is how well team members know each other. In order to address "I-Needs", it will be important for team members to know more about each other than "name, rank, and serial number". A second variable involves the team's ability to acknowledge and resolve normal differences of opinion and conflicts that may arise. Any time a group of people work together there are destined to be a variety of opinions on the task at hand. The key for successful team functioning is to be able to disagree without being disagreeable. A third factor in how effectively a team works is the degree of trust and cohesion that develops plus the openness of communication. This will be discussed in more detail later.

The fourth variable has to do with the stage of group development in which the team is functioning. All groups (no matter what their purpose may be) go through identifiable stages as they develop. At each stage there will be a different focus with respect to the three levels of needs:



The relative importance of I, We, and It needs at each stage of group development. (The key issue of each stage is shown in parentheses.)

Each team will move through these stages at different rates depending on how well the issues at each stage get resolved.

In the first stage the individual needs are most prevalent. This can best be described as the "honeymoon" stage as members get to know each other and figure out how and where each individual will fit. Key issues at this stage are testing and dependence. In order to move beyond this point, team members must be honest about their personal needs, goals, and biases regarding the group task.

As group members state honestly what they believe and want from the team, conflict and/or differences of opinion are inevitable. Many teams panic at this point and assume they are doing something wrong. In fact, they have moved to stage two or the conflict stage. Since the group must somehow reach consensus on rules, member roles, leadership, structure, and goals, there will be a period of struggle. Some of the individual needs must now take a back seat to the group or "We" needs. The key to moving out of this stage is honest communication and a willingness on the part of team members to compromise. This is where one must be able to disagree appropriately. Team members need to be able to say "I don't agree with that. In my opinion/experience..." instead of "That's stupid. It'll never work."

As the team moves into the third stage, the group needs become even more predominant. Individual team members have been able to fit their own individual needs to those of the whole and cohesion has now developed. The team is now fully a group with roles, rules, and a history. The crucial issue for any Core Team at this stage is to develop the necessary cohesion without becoming exclusive. The team needs to remain open to new members and needs to let people outside the group know what is being accomplished (without violating confidentiality).

The final stage of team development comes when the members have established healthy communication patterns and cohesion that remains inclusive. At this point the individual and group needs still exist and need to be addressed from time to time, but the focus of the team now becomes the tasks needed to reach the goal(s). Key concerns during this stage include the maintenance of team effort, planning for the future, establishing ways to avoid burn-out, and the rejuvenation of team members.

INDIVIDUAL ROLES:

As the team moves into the middle stages of its development and members develop roles, each individual will find that they have a preferred style of functioning. For the team to be effective, each member needs to understand their own style as well as being able to accept and appreciate those who may be different. Each style of group interaction and functioning is important as it fulfills a specific role. There are four primary categories that have been defined: the task person, the catalyst, the organizer, and the visionary

The task person is the member of the team who will make sure that the job gets done in the appropriate length of time. Task people are the members of a team who will call for a vote after discussion has been held, assign specific tasks and deadlines, and finish tasks that others don't complete. The downside to this role is that task people are often perceived by others as "bossy" or "dictatorial". However, if the task person can temper some of their desire to "get the job done at all costs" they can be a crucial member who keeps their team on track and ensures progress.

The catalyst is often the person who opposes the task person (or at least finds them difficult to accept). This person is more worried about how team members feel than whether or not the job gets done on time. They will mediate conflict, try to involve quiet members, make sure everyone feels comfortable, and acknowledge progress and success. While this team member may be seen as slowing down the process and being too "touchy/feely", they are very important to the maintenance of team morale and commitment. One of the most important keys to long-term commitment by team members is the regular celebration of success. It is the catalyst who will make sure this happens on a regular basis.

The organizer is the team member who wants to focus on priorities, structures, and methods for accomplishing tasks. Often, this person works very closely with the task member(s) of the team by establishing the activities and priorities needed to accomplish the particular goal. While it may appear that the organizer gets lost in detail and gets too picky about the steps, theirs is an important function also. Anytime you are trying to change a system or establish a new program, it is crucial to establish those activities that form the foundation and see that they are accomplished first. The organizer is also good at evaluating where the program is at this point and what would be the next logical step.

The final category of team functioning is the visionary. This is a person who is able to come up with lots of ideas during brainstorming sessions and is able to look at a problem from many different angles. They are high energy people and can stimulate discussion, sharing of ideas and "what if" questions. Although some of the ideas generated by the visionary may be a bit idealistic (or even bizarre), the team should be able to sort through to find ideas that will accomplish the task at hand. Without these ideas, the team would often flounder and get stuck in "That's the way we've always done it" or "Yeah, but..." instead of "What if".

Most team members will have a tendency toward one of these four categories, although most also have a secondary style. The importance of understanding how individual team members function is to be able to understand and accept each other's style and utilize each person's strengths.

DEVELOPING A HEALTHY TEAM:

Healthy teams all possess certain characteristics. These allow the team to move through the different stages with a minimum of trouble and to work together effectively. The characteristics include:

- Communication patterns that are clear and honest.
- A willingness and ability to recognize and deal effectively with conflict.
- Support for individual members.
- Roles and responsibilities that take into account a person's strengths and that are flexible.
- Cohesion that is inclusive rather than exclusive, making new members welcome.
- The ability to recognize and celebrate hard work and success.
- A willingness and ability to share feedback with each other in a constructive manner.
- An understanding of group process and an ability to use it effectively.

A team that develops these characteristics won't be able to solve every problem, but they will be more effective than a team with opposite traits.

To develop these traits there are three overall factors required. Each one relates to the other and they build on each other. These factors are: trust, cohesion, and communication. Without them it is difficult (if not impossible) to form a healthy Core Team.

Trust is the foundation upon which the team is built. As a team member, I need to be able to trust a variety of things. First, I need to be able to trust that other team members will respect and value my opinions and feelings and that I will be able to share a different idea without being put down. Second, I need to trust that everyone will be responsible and will follow through on the tasks they are given. And finally, I need to be able to trust that team members will keep personal information confidential. There may be times when I will want to (or need to) share personal information or feelings. Often Core Teams end up functioning in part as a support group for educators. When working with high risk kids, there will be emotions touched and there will be stress. Rather than taking that home, if I can share how I feel with the team, I can avoid burn-out more easily. At times the emotions that are touched may come from a personal experience. If I choose to share that, I need to know that the information I have revealed will not go outside of the room. The more this trust exists, the more cohesive the team will become.

Cohesion has already been mentioned as a crucial part of team development. The team needs to feel like a unit with shared goals and commitments. Obviously each member brings something different in terms of motivation, but all members must agree to be working toward the same end. As the team works together, a common history develops which enhances the cohesion. It is at this point that the danger of becoming exclusive exists. When new members try to come in and all they hear are war stories and tales of the "good ol' days" they will tend to feel like an outsider. Every effort needs to be made to share the feeling of cohesion with the new member and to make them feel welcome.

The cement that holds all of this together is communication. The primary characteristics of effective communication are that it is open, honest and non-judgmental. Robert Carkhuff, a psychologist and researcher, has identified some specific characteristics of good communication. These are:

- **Warmth:** Communication that sets a tone of caring, support and openness.
- **Genuineness:** Words and behaviors that are congruent.
- **Respect:** The ability to be non-judgmental and show appreciation for another person's feelings, thoughts, and beliefs.
- **Empathy:** The ability to understand what another person is thinking and feeling and being able to demonstrate this understanding.
- **Concreteness:** Addressing the issue at hand and being able to share in problem solving.
- **Self-Disclosure:** Being willing to share personal thoughts, feelings, opinions, and experiences that relate to other people.
- **Confrontation:** The ability to confront inconsistencies in a person's behavior in a non-judgmental way.
- **Immediacy:** Focusing on the present and the topic or issue currently being discussed.

As team members work on developing these skills, both trust and cohesion increase and the team becomes more effective in achieving its goals.

In order to develop an effective Core Team, it will be important to be aware of and work toward all of the factors that will enhance this development. Two questionnaires have been included that can be used to evaluate how well the team is functioning. But the most effective way to evaluate will be through communication about the group process and willingness to share concerns about the team's development. Although it may seem as if this will slow things down, the reality is that an effectively developing team will function much more efficiently than one which ignores the issues of group process.

QUESTIONS TO ASK ABOUT A GROUP'S PROGRESS

1. Do seriously intended contributions plop without response?

   A speaker needs to know the effect of his remarks so that he can compare it with what he intended. When others do not respond the speaker cannot know whether they --
   --did not hear him.
   --did not understand him.
   --understood and agreed with him.
   --understood but thought it irrelevant.
   --felt uncomfortable because of the issues he raised.

2. When a complicated, unclear, or controversial comment is made does the group check to make sure it understands what the speaker means before agreeing or disagreeing?

3. Does each member state his personal reactions as his own rather than giving the impression he is speaking for the group?

   Unless each person speaks for himself the group cannot take his views and feelings into account.

4. Are all contributions viewed as belonging to the group to be used or not as the group decides?

   A member who makes a suggestion should not have to justify, defend or become it's advocate. All members should take responsibility for evaluating it as the property of the group.

5. When the group has trouble getting work done, does it try to find out why?

   Symptoms of difficulty are--
   --excessive hair-splitting or nit-picking.
   --same points repeated over and over.
   --suggestions plop and are not considered.
   --private conversations in sub-groups.
   --two or three members doing nearly all of the talking.
   --members take sides and refuse to compromise.
   --ideas are attacked before they are completely expressed.
   --Apathetic participation.

   When such symptoms occur the group should shift from working on the TASK to discussing the interactions and feelings of members about the PROCESS of working together.

6. Does the group bring conflict into the open and deal with it?

   Because of the differences among individuals, conflict is inevitable. The group can only choose whether the conflict will be open (and, thus, subject to group control) or disguised (and out of control).

7. Is the conflict approached as a topic for joint inquiry into "what is best for us to do in this situation?" rather than as a competitive struggle to prove "Who is right and who is wrong?"

8. Does the group make important decisions by open agreement or by default?

   When a group views each decision as a provisional trial which can be carried out, evaluated and revised in the light of actual experience, it is easier to make decisions than when each decision is required to be so perfect that it can stand forever without change.

   When the group agrees on a decision which it does not carry out, it should recognize that the REAL decision was one not to act although the APPARENT decision was to act. The group should openly discuss why the apparent and the real decisions were not the same.

9. Does the group use different ways to make decisions depending upon the time available, the kind of issue, and the importance of the outcome?

   A group may vote, delegate the decision to a certain person-or sub-group, flip a coin, or discuss it until they reach complete consensus. The critical factor is that the group has complete consensus on the WAY used to make the decision in each case.

Adapted from a questionnaire designed by John Wallen, Ph.D.

SURVEY OF HOW WE WORKED

For each question, please circle the one number on the scale that best represents your opinion of the way the group worked. Please disregard how you feel about what the group accomplished and focus on how you worked together.

1. What was our usual participation pattern during this meeting?

4	3	2	1
Balanced: (Although we didn't all talk the same amount, I think each of us talked nearly the right amount.)	**Slightly Unbalanced:** (Some talked somewhat too much; others talked somewhat too little.)	**Unbalanced:** (Everyone talked, but some talked too little and others a great deal too much.)	**Extremely Unbalanced:** (A few did all the talking.)

2. Members who are not talking may either be tuned out or attentively involved. How many were attentively involved when they were not talking?

5	4	3	2	1
All	Most	Half	A few	None

3. How many occasionally checked to make sure that remarks were understood as they were intended?

5	4	3	2	1
All	Most	Half	A few	None

4. How many occasionally summarized (e.g., what we had accomplished, what we agreed on, what we disagreed on)?

5	4	3	2	1
All	Most	Half	A few	None

5. How many helped keep the discussion on track (e.g., by orienting us to our task or the goal of our discussion, by bringing back members who digressed)?

5	4	3	2	1
All	Most	Half	A few	None

6. Did we openly state our disagreements and discuss them rather than ignore them or try to pretend there were none?

6	5	4	3	2	1	0
Almost always	Usually	Slightly more often than not	As often as not	Slightly less often than not	Rarely	Almost never

7. When we had trouble making progress, did we openly discuss the signs of the difficulty and try to find the reasons for it?

6	5	4	3	2	1	0
Almost always	Usually	Slightly more often than not	As often as not	Slightly less often than not	Rarely	Almost never

After each team member has answered all seven questions, tally the responses. As each member calls out his rating for question 1, the others can tally the marks above the ratings called. After everyone has done this, each member will have a vivid picture of how the entire group responded on question 1, which can then be compared with his or her own rating.

Questions 2-7 can be tallied in the same way, one item at a time.

Adapted from a questionnaire designed by John Wallen, Ph.D.

BECOMING A TEAM MEMBER

1) Why are you a member of the team?

2) What strengths do you bring to the team (at least 3)?

3) What tasks or goals would you like to be involved in? (prevention, intervention, policy, etc.)

4) What do you set as the overall purpose of the team?

5) What would you like the team to accomplish during the next school year?

PRO-ACTIVE TEAM PLANNING

Need to be Addressed:

Overall Goal:

Specific Objectives:

1.

2.

3.

Assets	**Liabilities**

Step #1:

What:

Who:

When:

Step #2:

What:

Who:

When:

Step #3:

What:

Who:

When:

Desired Outcome:

TEAM BUILDING STORY

On a dangerous seacoast where shipwrecks often occur there was once a crude little lifesaving station. The building was just a hut, and there was only one boat, but the few devoted members kept a constant watch over the sea, and with no thought for themselves went out day and night tirelessly searching for the lost. Many lives were saved by this wonderful little station, so that it became famous. Some of those who were saved, and various others in the surrounding area, wanted to become associated with the station and give of their time and money and effort for the support of its work. New boats were bought and new crews trained. The little lifesaving station grew.

Some of the members of the lifesaving station were unhappy that the building was so crude and poorly equipped. They felt that a more comfortable place should be provided as the first refuge of those saved from the sea. So they replaced the emergency cots with beds and put better furniture in the enlarged building. Now the lifesaving station became a popular gathering place for its members, and they decorated it beautifully and furnished it exquisitely, because they used it as a sort of club. Fewer members were now interested in going to sea on lifesaving missions, so they hired lifeboat crews to do this work. The lifesaving motif still prevailed in this club's decoration, and there was a liturgical lifeboat in the room where the club initiations were held. About this time a large ship was wrecked off the boast, and the hired crews brought in boatloads of cold, wet and half-drowned people. They were dirty and sick, and some of them had black skin and some had yellow skin. The beautiful new club was in chaos. So the property committee immediately had a shower house built outside the club where victims of shipwreck would be cleaned up before coming inside.

At the next meeting, there was a split in the club membership. Most of the members wanted to stop the club's lifesaving activities as being unpleasant and a hindrance to the normal social life of the club. Some members insisted upon lifesaving as their primary purpose and pointed out that they were still called a lifesaving station. But they were finally voted down and told that if they wanted to save the lives of all the various kinds of people who were shipwrecked in those waters, they could begin their own lifesaving station down the coast. They did.

As the years went by, the new station experienced the same changes that had occurred in the old. It evolved into a club, and yet another lifesaving station was founded. History continued to repeat itself, and if you visit that sea coast today, you will find a number of exclusive clubs along that shore. Shipwrecks are frequent in those waters, but most of the people drown![1]

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[1] This parable originally appeared in an article by Theodore O. Wedel, "Evangelism—the Mission of the Church to Those Outside Her Life," The Ecumenical review, October, 1953, p. 24. The above is a paraphrase of the original, by Richard Wheatcroft. It appeared in Letter to Laymen, May-June, 1962, p.1.

STUDENT ASSISTANCE PROGRAM DESIGN

As stated earlier, a Student Assistance Program (SAP) is a comprehensive program which has as its goal the creation of a supportive school/community environment promoting wellness and success in all students. In the past, the sole focus of most SAPs was to intervene with chemically involved students. Although this is still a very important part of an SAP, the majority of programs have been expanded. Intervention with all high risk behaviors (including suicide, delinquency, teen pregnancy, etc.) is seen as important and within the realm of the program. In addition, prevention has become much more of an issue so that instead of working with only a small percentage of drug-involved kids, SAPs now deal with the entire student population. This also means that the focus needs to be on developing a program that runs grades K - 12.

Student Assistance Programs were described in the section on Core Team Development as having eight basic components that fit into three areas or "tracks"; Administrative, Kid-Centered, and Intervention. Each track is important individually, but collectively they support each other and form a comprehensive approach to wellness. The Administrative Track involves the "behind-the-scenes" tasks of policy and accountability (or record-keeping). The title, "Administrative", does not mean that only administrators are involved. It means that these are tasks that are generally considered administrative in nature. The Kid-Centered Track includes all activities that directly or indirectly effect all students in the school or community and help to promote and encourage wellness. Awareness, Prevention/ Education, and Support are activities that focus on all students, not just the ones involved in high risk behaviors. In fact, these activities are generally not effective for students who are already drug addicted, suicidal or pregnant. For those we need the third track of Intervention. This is the one that most people think of when they hear the words "Student Assistance Program". This is where SAPs started. The Intervention Track involves identifying high risk students, intervening with them and/or their parents, and making a referral to outside resources if necessary. The key with this third area is understanding that an SAP is not about diagnosing and treating. It is more about recognizing dysfunctional, out-of-norm, behaviors and getting the students to a place outside of the school where they can get help. School personnel can then support that process, but treatment needs to happen outside of the school building.

TRACK #1

Policy: This is the foundation of the Student Assistance Program. Without a clear, consistent policy that outlines expectations for behavior, it is very difficult to address high risk, out-of-norm behavior. The policy establishes the norms and also outlines the consequences for violation.

There are several things to be considered when looking at policy whether it be the basic discipline code or specific alcohol and drug policy:

1. Is the policy known by all populations? It is important for people to know what the policy states. This is true for teachers who have to enforce the rules, students who have to abide by the rules, and parents who need to support the school's enforcement of the rules. Whether this knowledge is disseminated through inservices, assemblies or handbooks is not important. What is crucial is that everyone know what the policy of the school dictates.

2. Is the policy followed consistently? Nothing causes more problems in a school setting than policy statements that are not consistently implemented. When a school system allows one child's behavior to be overlooked or lets them get off with a "lighter sentence" and then strictly enforces the most severe consequences of the policy with another student, problems arise. The first student is enabled in the sense that they do not experience the consequences of their behavior and will be likely to do the same thing again. The second student becomes angry and resentful that they got in so much trouble when others did not. Once a policy has been established, it needs to be implemented consistently. Consideration can be given to individual circumstances, but the consequences need to be followed.
3. Does the policy make sense? In particular, does it make sense to students. If a student understands why a particular policy exists, they will be more likely to follow it, even if they don't like the rules or consequences. If, however, the rules or consequences are arbitrary (or seem to be) they will be less likely to be followed.
4. Are the consequences logical? The punishment needs to fit the crime and needs to have a likelihood of diminishing or discouraging the unwanted behavior. An example of an illogical consequence is suspending a student for skipping school. In essence, the student's behavior is rewarded by giving them what they wanted in the first place. A more logical consequence would be in-school suspension where they are isolated from friends or additional time in school through detentions or Saturday school.

5. Are the policies reviewed and updated on a regular basis? Just because something worked in 1962 does not mean it will work in 1990. Policies need to be reviewed every few years and revised as needed to reflect the changing environment of the school.

With respect to specific alcohol and drug policy (possession of a substance or being intoxicated in school), the following questions need to be asked:

1. Is the policy simply punitive, or is there an opportunity for a student to get help? Most student assistance program policies have established systems which allow the student to reduce the length of the consequences if they voluntarily go for an assessment with a substance abuse professional. It is important that the consequences not be eliminated entirely, just reduced. This also occurs only on the first offense. Generally, on a second offense, the policy would state that the student must serve the full consequence and have an assessment completed. Assessments will be discussed in more detail later.
2. Does the policy regarding alcohol & drug possession include involvement of law enforcement? Possession of alcohol and other drugs is a legal issue as well as a school policy and health issue. Many schools have developed a working relationship with the local police department to make a referral for any possession (or distribution) incident. One advantage to this is that if the child needs to have an assessment done or needs treatment, the legal system often has more leverage to force compliance.
3. How is sale and distribution handled as opposed to possession for one's own use? Most schools choose to handle this issue as a strictly legal one. However, there does still need to be some

consideration given to the idea of assistance. A child who is selling drugs in school desperately needs help. Through the legal system (particularly when schools, courts, and parents all work together), it is possible to have the child receive treatment, even if they don't want it. When dealing with addiction, it is generally a mistake to wait until the person wants help as the end stage is often death.

If all of the above considerations are examined, and if the policies developed follow these guidelines, the chance for success increases dramatically. In addition, school policies serve as protection in the event of resistance or legal threats. If the policy is written and adapted, and it is followed precisely (including written documentation of behavior and subsequent action) little can be done by way of legal action. This will be discussed further under the Intervention Track.

Accountability: This refers to the task of monitoring and evaluating the program. One of the problems with many new ideas is that they get implemented in a haphazard fashion and no one takes the time to evaluate their effectiveness. Accountability might cover several areas:

1. Number of students serviced: The basic task of keeping records regarding how many students are actually served by the program. This becomes important in justifying future funding or the addition of positions. Also included could be a breakdown of the number of females to males and the percentage of each ethnic group. This tells us if the program is more effective in getting one particular group involved over another.
2. Listing of programs offered and attendance at each: This list would include the assemblies, prevention programs, support groups,

peer helping groups, etc. and how many students were involved in each. Again, this helps to justify the program and its expansion as well as identify which programs seem to be most positively received. This could also include a record of how many staff have attended inservice training regarding the program.

3. Updated surveys of student use, attitudes, and school functioning: To determine whether the program is having an impact, a survey of the student body becomes an effective tool. The survey needs to be well thought-out and anonymous. With this survey, a school can get an idea about any change in behavior or attitudes of students as a result of prevention/education/intervention programs. Surveys will be discussed further under Awareness activities. Accountability can also include keeping track of school success to see if there is any change in grade point averages, truancy, or drop-out rates. Many schools who have implemented SAPs have found a dramatic, positive change in these areas.
4. Number of hours spent on the SAP tasks: One thing that several schools have done is to keep track of the number of volunteer hours spent on SAP issues and have used those figures as a way to justify creating a new position. Often, as SAPs get larger and more comprehensive, a coordinator is needed to assure that there is no duplication of efforts and that all needs are being met. Generally, being able to show number of hours spent working on program issues, along with positive outcomes (ie: reduced truancy or drop-out rates), helps to justify hiring a coordinator.

Each individual program may have other specific information needed. This information can be used to:

1) Celebrate the success of the program.
2) Modify the program.
3) Expand the program and create new positions.
4) Secure funding from federal, state, and local sources.

So although accountability may not be the most exciting or noticeable task, it is an area that cannot be overlooked when establishing a Student Assistance Program.

TRACK #2

Awareness: The awareness component and the education/prevention component, described next, tend to overlap in many ways. One of the primary differences is the target audience. Awareness activities generally focus on the adults in the school and community. Education/prevention addresses the needs of the student population. The goal for Awareness is to increase knowledge about dysfunctional behaviors and high risk kids and begin to change attitudes and behaviors. An example of such a change would be altering the belief of some that alcohol is an acceptable drug ("at least the kids are only drinking and not doing drugs"). It might also involve getting adults to examine their own behavior and to begin modeling healthy coping skills.

Depending on the needs of the group, awareness activities can take a variety of forms. For school personnel, they generally entail training about high risk youth and SAPs. Topics might include:

* recognition of high risk students - signs and symptoms
* professional enabling and how to turn it into empowering
* intervention skills

- establishing a student assistance program
- adolescent substance use and abuse
- adolescent suicide
- core team development and team building
- developing and facilitating support groups in school

As was mentioned in the Core Team Section, this training generally takes place initially as an intensive workshop on establishing an SAP and then as a series of shorter inservices. A needs assessment is often conducted prior to inservices to determine the exact topic to be presented.

For parents and community members this component involves activities to heighten awareness about high risk youth, SAPs, and how the community can be involved. Obviously there is some overlap with school personnel, but there are specific projects that involve the community members. As with school personnel, a needs assessment is often beneficial to find out what people want and/or need (often two different things). Activities can then be established from this assessment and might include:

- a public information lecture series
- brown bag lunch event
- projects to raise funds for SAP activities
- health fairs at school or community locations
- articles in the local newspaper
- community newletters
- parent networks
- special projects such as Project Prom/Graduation or Red Ribbon Week

The primary goal for any project developed is to get as many people from the community involved as possible and to begin talking about issues that most people would rather ignore.

Although awareness activities are generally attempting to reach adults, this is also a good time to get students involved. After all, they are a part of the community and the focus of the school system. We also know that the development of healthy, supportive, positive relationships with adults help to steer kids toward success and wellness. What better way to have students interact with adults than through activities that promote positive changes in the community? The students have access to adult role models, and if they are allowed to be a part of the planning process they can begin to feel important and capable. They can watch the decision making process and begin to practice this skill, at first as a part of the awareness committee and later in their own lives.

A final, and important, consideration in the awareness component is the need to break through community denial. Most communities would like to believe that "things are not all that bad here compared to over there". Although each community does have its own unique problems which may be statistically more or less than another community's problems, the fact remains that no one is immune. Some of the best and brightest students use alcohol and other drugs, are at risk for suicide, have eating disorders, etc. Likewise, many of the most progressive, affluent communities have serious problems with these same issues. Awareness activities need to address the beliefs that allow a community to say "not our kids" or "not this group of kids" or "we don't have nearly as many problems as that other community". One of the ways to do this is through a student survey. Although national statistics are available which tell us that 90-92% of all high school seniors have tried alcohol, it is still easy to say "our kids are different". When a local survey has the same findings it is harder to deny.

Many surveys exist that have been developed for use with students. Some are available through research firms that will tabulate the results and provide a report on the findings. Obviously these cost money, usually a dollar figure per student involved. Others have been developed by an individual school for their own use, but may be made available to neighboring schools free of charge. These are free, but usually have not been tested for validity or reliability. According to the Western Center for Drug-Free Schools and Communities, there are four questions to be asked when considering the use of the particular survey instrument:

1. Content - Does the survey ask the questions you need asked?
2. Technical Characteristics - Does the survey possess sufficient reliability, validity and sensitivity? (Sensitivity refers to the ability to detect changes or differences that are very small, but are still meaningful). Most local surveys may, in fact, have these characteristics but have no research to support this.
3. Utility - Is the survey manageable and useful in terms of cost, time (length) and available support systems?
4. Special Considerations - Does the survey include any special characteristics needed in your own context (e.g. - spanish translation, reading level appropriate for LD students, etc.)

The answers to these questions will then tell you what you need to know about the quality and applicability of the instrument.

A fifth consideration regarding student surveys which was not discussed by the Western Center for Drug-Free Schools and Communities involves outcomes. A very important question to ask prior to administering a survey is "What are we going to do with the results?" There are two reasons for deciding this ahead of time. First, if it is known up front what will be done with the information, it is easier to decide what to ask. Why have a list of questions about study habits if there is no intention of addressing that issue? The second reason to decide how the information will be used before collecting it is to avoid having the results bias that decision. If the results do not come out as expected or wanted, will they be suppressed or published? If this decision is made ahead of time, there is less of a chance that the information will be "filed for later use". If the survey is going to be used as an awareness activity, it has to be made public knowledge. For some schools this involves holding a press conference, sending out a summary to all parents and community leaders, and/or presenting the data at a public meeting.

Prevention/Education: One of the best metaphors for prevention is illustrated in the following story:

UP THE DOWN STREAM

People in the field of Prevention tell the story about a family that had picnicked on a riverbank on a hot summer's day. They laughed, talked, ate their lunch and enjoyed the fresh breeze from the river. Suddenly, grandpa yelled, "There's a baby coming downstream."

He jumped into the river, grabbed the baby and got it up on the riverbank. No sooner had he breathed life into that baby when he heard another cry from the river. Grandpa jumped in again, and as he reached the second baby, he saw a third. He heard his daughter calling from the riverbank as she pointed to more babies floating downstream. Within minutes the whole family jumped into the water. Desperately, they tried to save the babies who continued to come.

Grandma surveyed the situation and began running upstream.

"Where are you going?" her family cried, "We need your help."

'I'm going upstream to find the fool who's throwing all these babies in, and I'm going to stop him."

Whereas the target population of the awareness component is primarily the adults in the school and community, prevention/education focuses on the students. The goal of these activities is to increase students' ability to make healthy choices by providing accurate information, new skills, and healthy alternatives for behavior. In most programs, this component gets divided into two sections: curriculum and prevention activities.

The area of prevention/education has had an interesting history. It began in the 1960's with scare tactics designed to convince kids that they shouldn't use or they would end up dead or insane. There are many problems with this method. First, they were generally "one-shot" efforts with no follow-up. Research has shown that even if programs are excellent at motivating students, if they are not on-going the results last approximately two weeks. Second, most kids think they are indestructible, so programs that try to convince them that they will die or get hurt do not generally phase them. "It will never happen to me, I'll be careful." Finally, since most people do not end up dead or crazy when they initially use alcohol or other drugs, programs that stress this issue end up sounding like a lie. The reason that most people use chemicals is that they make him/her feel better. Scare tactics did not address this fact and, therefore, were generally ineffective.

The 1970's saw two different types of prevention/education. In the early part of the decade the focus was on presenting facts and information only. Rather than scare tactics this was intended to be calm, rational, clear data about what alcohol and other drugs were and how they acted in the body. What happened was that these programs produced better informed consumers. Alcohol and other drug use actually went up as a result. So the switch came in the second half of the 1970's to a concentration on affective issues. In effect, the pendulum swung the other way. The idea was valid - if kids are using drugs to feel good, let's teach them how to deal with feelings in other ways. Unfortunately, this was only one piece of the puzzle and did not address any of the other reasons kids use, such as peer pressure, curiosity, and a desire to be "adult".

By the early 1980's the focus had shifted from feelings (which didn't seem to make a difference) to behaviors. The idea was to offer students things to do with their time and in their peer groups that did not involve drinking and drug use. Unfortunately many of these programs were developed by adults without asking kids what they liked doing as alternatives. Consequently, kids either did not come because the activity did not interest them, or they came and then went out afterward and got loaded because they weren't invested in the process. Again, drug use continued to climb to epidemic proportions.

With the possible exception of scare tactics, none of the previous attempts were all bad. The problem with each was that it only addressed one facet of a very complex issue. In the late 1980's prevention programs began to be more comprehensive. The most effective prevention process appears to be one that encompasses five strategies. The first is awareness and information. This includes not just alcohol and other drug information (pharmacology), but also information about addiction, consequences of use, and resources for help, if needed. The information needs to be appropriate to the audience both in terms of interest and needs, and also in terms of level of understanding and maturity.

The second strategy involves social competencies and teaches such skills as communication, self-awareness, decision-making, friendship skills, stress management, assertiveness, and refusal skills. Having information is useful, but one of the things that was lacking in the past was the development of the skills necessary to utilize the information. Also included in this is the need to implement programs which help foster positive self-esteem in students (this will be discussed in more detail in a later section). For a child to use the skills they have learned they must feel they are worthwhile.

The third part of a comprehensive prevention program involves positive alternatives. This is similar to the attempt tried in the early 1980's, but is now one piece of a larger program. As with factual information, alternatives need to consider the students' age and maturity level. They tie into social competencies by facilitating the development of life skills, particularly friendship and communication. And they foster a sense of involvement and commitment, particularly if students are involved in the planning process.

Fourth in the list is policy. Although most people do not automatically think of something that involves consequences as a part of prevention, it really is. Policies establish boundaries for acceptable behavior and ultimately impact social norms and behaviors.

Finally, prevention programs include the training of impactors. This ties back into awareness and Core Team development with training for educators, parents, and community members about high risk kids and Student Assistance Programs. Since the prevention programs will be coordinated by the school staff (hopefully with input from students, parents, and community members) these individuals need to have as much information as possible about high risk behaviors and prevention strategies.

One important note on prevention/education programs is that although the usual target population includes all students, the reality is that students who are already involved with dysfunctional behavior are not reached by these efforts. With prevention, the goal is to change attitudes and behavior before a student gets in trouble. For this reason, the most effective prevention/education programs begin in kindergarten. Beginning a prevention program in high school, when many students are already using and are already experiencing difficulties, does not make sense. The foundation needs to be built early so that when the time comes to make the decision whether or not to use, the child has the necessary skills and knowledge.

Prevention activities take a variety of forms. Some are done as assemblies with a whole school or grade level present. From the point of view of time, these programs are very useful. The danger, however, is that without any follow-up in smaller groups, the behavior changes do not last. One way that many schools do this follow-up is to build in time after the assembly for students to meet in homerooms or small groups and discuss what they learned. Later, assignments in various classes can be geared to the concepts discussed in the assembly. A second type of prevention program is having an all day or multi-day program such as Snowball or Teen Institute. With these programs students are able to spend alot of time talking about feelings, learning new skills and information, and interacting with each other in positive ways. Again, some kind of follow-up, such as a mini-snowball or a reunion, is crucial for the learnings to become an integral part of the student's behavioral repertoire. The key to prevention activities is to assess the needs of students, invite their input, and be as creative as possible. Prevention programs that are developed by (and sometimes run by) outside people are often very good, but only if the local school personnel, community members, and students take an active role in the implementation.

In addition to prevention activities, the Prevention/Education component generally includes some type of substance abuse curriculum. In this case, most schools purchase some form of package which generally includes the lesson plans, materials, and audio-visuals. A training process is usually included, although a few are designed to be self-explanatory. The problem with most of these packages is that they end up being implemented sporadically at best. The more complicated the curriculum, the more likely it is that this will be the case. The other problem is that they are often designed as a separate class rather than a part of the on-going class process. This often means a unit of a set length (often 2 - 12 weeks) that is either done in a health class or fit into an already crowded schedule. The information being provided and the activities involved may be wonderful, but after the unit is over and things go back to normal, students tend to forget what they learned (similar to the lapse of memory that occurs over summer vacation).

The most effective method of implementing curricula is to try to have it be a part of the regular educational process. Although this is difficult to do since it is more time consuming, it is much more effective from the stand point of prevention. As new curricula are being designed, or older ones are being revised, attempts are made to at least provide some suggestions for integrating each concept or lesson into English, History, or Science. A booklet published by the U.S. Department of Education in 1988 entitled "Drug Prevention Curricula: A Guide to Selection and Implementation" attempts to address some of the issues surrounding curricula including whether it makes more sense to buy one, adapt parts of several, or create one from the beginning.

A specific problem concerning the special education population, and mentioned earlier, is that most packaged curricula has been developed with the mainstream student in mind. As more and more emphasis is given to combating drug use and other high risk behaviors, attention will need to be given to these students and programs adapted to their needs.

Support: In discussing risk factors in the previous section, the need for a support system was discussed. This support system can come from a variety of sources, but historically included the network of the extended family. These networks form the places where an individual can validate roles, test assumptions, and share experiences and wisdom. In today's mobile and isolated society, the active network of grandparents, aunts and uncles, cousins, in-laws, and neighbors has been harder and harder to find. Because of this, the peer group has become the primary support system for young people. Unfortunately, this has led to increased involvement in gangs as well as an enormous power of the peer group as children struggle to feel listened to and taken seriously. Often these peer groups hold in high regard the rebel or delinquent and push the use of chemicals, thus supporting dysfunctional behavior.

The third component of the Kid-Centered activities involves building healthy support systems which can then reintroduce the concept of positive networks. Often this is done in the school setting through a structured support group. This term has been used to describe a myriad of different experiences. For the purpose of this process it is defined as "voluntary small group structures formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or lifestyle-disrupting problem and bringing about desired social and/or personal change." (Katz and Bender, 1976) These school based support groups address a variety of issues such as students recovering from addiction, children from dysfunctional family systems, low self-esteem, children of divorce, eating disorders, teen pregnancy, etc. The group may be open or closed, on-going or a set number of weeks and may address one specific issue or be more generalized. Regardless of the structure, the primary goal is to create a safe, supportive environment where students can share concerns and begin to interact with each other in healthy ways.

Support groups in the school setting, especially those that are a part of a larger Student Assistance Program, generally help to take stress off the educational system and facilitate individual jobs. Since one or two people can work with up to 10-12 students at a time, larger numbers of students needing help can be serviced. It is important to remember, however, that as effective as support groups are they must not cross the line into therapy. A school setting is not the place for long term, intensive treatment to occur. If a student needs more than can be provided in a support setting they need to be referred elsewhere and this will then fall under the third track of the program (Intervention).

The specific objectives of a school-based support group have been outlined by Cheryl Watkins, M.A. (1989) and are as follows:

1. Reduce feelings of isolation and loneliness by providing a sense of connectedness with self and others;
2. Identify self-defeating behaviors and break through denial and delusion;
3. Practice and receive support for healthy living skills;
4. Receive nurturing and affirmation for growth;
5. Learn how to identify and express feelings;

6. Increase self-awareness and self-esteem;
7. Provide validation, support, and encouragement;
8. Reduce feelings of shame;
9. Learn how to form healthy relationships;
10. Provide a trusting and safe environment for growth;
11. Learn how to care for oneself, how to care for others, and how to let others care.

As these objectives are met, networks begin to form and the peer structures that condoned or encouraged dysfunctional behaviors begin to support healthy choices and functioning. This then allows students to focus more positive attention on school and be more successful in academics.

TRACK #3

Identification: Whereas the previous track deals with the general student population, this track focuses specific attention on those students who are beginning to exhibit dysfunctional behavior. The goal here is to identify these students as early as possible since change comes easier before the behaviors become too entrenched.

The key to Identification is to remember that this is not about diagnosing. Identification refers to the observation and documentation of out-of-norm or problematic behaviors. It is not appropriate for school personnel, whose job is to educate students, to be taking on the role of a diagnostician (unless that is part of the individual's job and training). There may be times when the child will tell you what the problem is or when you will have a guess, but the primary focus here is on documenting the behavior and then getting the student some help.

The majority of students who are experiencing problems and becoming high-risk will exhibit "red flags" or warning signs that can be documented. Some of these red flags will be indicative of drug use, some of suicide, others that a child is living in a dysfunctional family. Regardless of the cause, the behaviors can be documented and an intervention conducted (discussed next). Some of the warning signs are:

- Changes in attendance
- Chronic truancy
- Chronic tardiness
- Decreasing academic performance
- Failure to complete assignments
- Increased discipline problems
- Lack of interest in activities (particularly if this represents a change)
- Change in peer group
- Increased irritability, moodiness, and aggression
- Withdrawal and/or depression
- Death or suicidal themes in writings or art work
- Comments about death and dying
- Comments suggesting a sense of hopelessness
- Selling or giving away possessions
- Changes in personal hygiene, clothing or habits
- Self-inflicted pain or injury
- Reported alcohol/drug use
- Possession of alcohol or other drugs
- Extreme mood swings
- Time disorientation or memory lapses
- Rigid perfectionism

- Hyperactivity
- Excessive clowning or joking
- Defensiveness about behavior

This list is by no means complete, but it begins to give the idea of identification. If several of these behaviors are noted (particularly if there seems to be a pattern) it is cause for concern and may require some type of intervention.

One final word of caution regarding the identification process. Given the erratic nature of adolescence, any one of these behaviors in isolation is generally not enough to cause concern (with the exception of talking about suicide which should always be taken seriously). Instead, several behaviors occurring simultaneously, particularly if there has been a sudden dramatic change, are more likely to be indicative of trouble. The key to identification is to look for changes in behavior and for patterns.

Intervention: The term "intervention" is one which was coined by Vern Johnson, of the Johnson Institute of Minnesota, to describe his method of helping families use confrontation to interrupt the course and progression of chemical dependency. The process involves precipitating a crisis for the addict using a safe arena and concrete data from as many family members as possible. The hope, and often the reality, is that the data shared in a caring manner will break through the denial system and motivate the person toward treatment. In essence, the process forces the addict to "hit bottom" early, before the final bottom of early death is reached.

Since the development of intervention for chemical dependency, it has been discovered that the same process can be used for other dysfunctional behaviors. Being that the primary focus of intervention is data about behavior shared in a caring, non-judgmental manner, it does not seem to matter if the cause is chemical dependency or depression. The process is the same. Similarly, although the early interventions were designed for families, the same process can be used by school personnel to intervene with out-of-norm behaviors exhibited by students.

The primary goal of an intervention process should be seen as creating an environment conducive to change. The goal is not to "fix" a student since no individual has the power to "fix". Instead we want to break through the denial system of the student and/or parent and motivate the student to change his/her behavior or accept help in doing so. To achieve this goal, four criteria need to be considered:

1. Obtaining observable data: The forms on pages 177 through 179 can be used to facilitate this process. The important thing is to look for behaviors and not make judgements.
2. Expressing of care and concern: In order for the individual (parent or student) to be in a position to hear the data, it must be shared in a way that is caring and non-judgmental.
3. Keeping things short and simple: People will be able to hear things easier if they are not bombarded with too much. Share enough data to break through the denial but not so much that it sends them into "overload". And as soon as agreement is reached that the child will get help, the intervention is over (even if there is still more data).
4. Developing the ability to counter resistance: When confronted with the truth, most people will want to attack. They will yell, blame, cry, swear, or refuse to talk. Knowing that this resistance comes from fear, guilt and frustration and developing ways to break through it is crucial to an effective intervention.

Although these four criteria do not guarantee a successful intervention, they do make it much more likely.

There are three basic types of interventions, all of which should be seen as part of a process. Intervention neither begins nor ends with a specific activity or event. Instead, it is generally a series of events that sets in motion the process of change. For the majority of these students we need to remember that it took them awhile to develop problems, and it will take time to change.

The first type of intervention, and usually the one that occurs first, is the "informal" one. This tends to be a one-on-one intervention between a teacher and student or a teacher and parent. If you think about it, these are activities that occur all the time but may not have been referred to as "interventions". Any time a teacher shares information about behavior with a student or parent, an informal intervention is being done. Occasionally a behavior contract may be used to increase the likelihood that a students behavior will change. In any event, a time frame needs to be outlined during which the change is expected to occur and a follow-up discussion held to evaluate the extent of change.

If the informal intervention does not result in a positive change in behavior, it does not mean that you have failed. What it indicates is that the problem is more serious than originally thought and cannot be handled through an informal intervention. At this point a more structured intervention (also known as a "formal" intervention) may become necessary. In most SAP processes the teacher observing the problems would be asked to fill out the "Student Referral Form" on page 177-179 and deliver it to the designated person on the school's intervention team. The goal now becomes finding out how pervasive the problem behavior is and what other behaviors have been observed. The same form with the "Staff Response Form" coversheet on page 175 is distributed to all staff who have contact with the student with a request that it be returned within a set period of time.

Other material such as attendance records, discipline reports, and previous report cards can also be collected at this time.

Once all the data has been collected, the intervention team would then sit down and discuss what has been found. Patterns are examined and previously attempted interventions or contacts documented. If it appears that there is a pattern of out-of-norm behavior, the discussion needs to focus on what has been tried and what the next step would be. In many cases, by the time the intervention process reaches this point, the next step is a referral to an outside agency for an assessment (discussed next). Regardless, if a formal intervention is needed, the focus is now on intervening with the parents to motivate them to seek help for their child. Often this will be very similar to a staffing with individuals sharing concerns and observations with the parents and a recommendation for the next step being made. Remember, the process is to share the collected data with the parents in a caring, non-judgmental way that reduces defensiveness and denial.

There are three other forms that are often used during the formal intervention process. The first is a feedback sheet for the people who initiated the referral and responded to the request for information. (page 181). It is important for the survival of the SAP program to acknowledge people's effort and time. In many programs, when teachers have filled out referral forms and not gotten a response, they have gotten frustrated and decided that it is not worth their time if nothing is going to happen. Just letting someone know that their form did not get buried on a desk or thrown away is good public relations. The second additional form on page 183 is one that can be used as a coversheet to get updated information on a child. In some cases, the decision of the team will be to monitor a child rather than do a formal intervention at this time. If this is the case, a method to gather further observations is necessary. Finally, page 185 and 136 is a form that a team might use to facilitate the review process and help in deciding how to handle a particular case. All of these forms (including the referral forms) should be viewed as models and can be revised depending on the needs of the particular program.

The third type of intervention is usually handled differently than the other two. It is a "crisis" intervention and is used when a school has a child who is actively suicidal or has taken an overdose of a chemical. This type of intervention is handled more along the lines of a "fire drill" in that a plan needs to be drawn up outlining who is responsible for handling each step. The overall process would be to monitor the child at all times, contact the parents, and make an immediate referral to the appropriate outside agency (suicide assessment or hospital). This type of intervention is handled immediately rather than planned carefully over a period of days or weeks which is the reason for having the plan outlined before it is needed. This was discussed in more detail in the section on Suicide.

Referral: Since schools are not in the business of providing treatment, there will be times when a referral needs to be made to an outside agency. Generally if the intervention process reaches the formal stage, and definitely if it becomes a crisis, a referral will be necessary. In this event, there are several things which must be considered.

First, in order to make a referral and have the process be smooth, it helps to have the school policies and procedures address this specifically. An outline of how, where, when and why a referral may take place will alleviate confusion later on. In some instances schools have made the referral a required part of staying in school (usually this is after everything else has been exhausted). If the referral is going to be a condition of continued attendance at school, it must be made a part of the policy statement and parents must be made aware of this fact.

The second consideration is that a referral that comes from a school needs to be for an assessment, not treatment. Since the identification process does not diagnose, the step following intervention would be to make a determination about the causes for the behavior. This assessment needs to be conducted by someone trained and experienced in adolescent behavior. The assessment typically involves an interview with the child and the parent (both separately and together) with questions specifically geared to break through denial. Also used in the assessment would be any information from the school regarding behavior and performance (a signed release of information is needed to share this information). After the individual doing the assessment has made a preliminary diagnosis, a recommendation is generally made for the appropriate treatment (if needed).

A second reason for referring for an assessment rather than treatment involves money. Most hospital-based or community mental health agencies will provide free assessments as part of their outreach. Treatment, on the other hand, can cost quite a bit of money (up to $15,000 or more for an inpatient substance abuse treatment program of 6 weeks). If the school refers a child to treatment, the cost will then be billed to the school. If the recommendation for that treatment comes through the free assessment the parents are responsible for the bill (often covered by health insurance).

Other things that facilitate the referral process (and are interrelated) include developing personal relationships, setting up a method for follow-up, and establishing lines of communication. The first step to all of these is to meet and talk to as many people at various referral sources so that there is a personal contact. Calling an agency to talk to a specific person as opposed to calling for anyone available, generally leads to better, more efficient service. This connection also facilitates the exchange of information after the referral is made which facilitates the follow-up process. Being able to find out whether or not the child kept the appointment, what was recommended and whether they followed through on the recommendation will assist in making plans at school. If the child is admitted to a treatment process, the school needs to be involved as much as possible to facilitate re-entry to the classroom. All of this improves the referral process and increases the likelihood of success for the student.

Confidentiality: An important consideration for Identification, Intervention and Referral is Confidentiality. When dealing with substance abuse issues, in particular, students are protected by Federal Confidentiality Regulations. There are also a number of state regulations that apply, although generally the federal ones are stricter and require more confidentiality. The bottom line of these laws is that the school must obtain a written release of information signed by the child and parent (if the child is under 18 - which most are) before releasing any information about possible drug or alcohol problems. The only exception would be if there is a medical emergency (suicide or overdose) or the student has been caught in possession of alcohol or other drugs on the school grounds.

Interestingly, information about school related behavior that is not specific to alcohol/drug problems (such as attendance, grades, dress, discipline referrals, etc.) may be shared without consent. The only stipulation is that the release must be done for the purpose of serving the best interests of the child. In particular, this allows SAP programs to share behavior checklists and grade reports with another school if the student transfers or is promoted. This helps in the continuity of the program and may alert the new school to potential problems. Just remember to stick to observable behaviors rather than opinions.

Legal Issues: One final note to the Intervention Track has to do with legal issues. Many school personnel get very panicky about intervening and making a referral because they do not want to be sued. It is true that there have been some lawsuits regarding Student Assistance Programs and interventions, however they are also easily avoided. There are four simple steps to avoiding legal ramifications when conducting interventions:

1. Have a policy and procedures statement which outlines the identification, intervention and referral process and have it approved by the school board. Make sure that all parents, students, and faculty are informed about the policy.
2. Document all warning signs, making sure to stick to observable behaviors without making any diagnosis.
3. Document each step of the process. If it's not written down, it didn't happen.
4. Make sure any referrals are for an assessment, not for treatment.

By following these steps, the school cannot be sued or held financially responsible.

On the other hand, the SAP team needs to make sure that the intervention process gets implemented. If a school notices out-of-norm behavior but does not bring it to the attention of parents, the school can be held liable for future problems. So the best plan is to identify (not diagnose) students' out-of-norm behavior, utilize the established intervention procedures, notify the parents of all concerns, and make referral for an assessment (not treatment) when necessary.

SUMMARY

To be a truly comprehensive Student Assistance Program, the focus needs to be on more than intervention. Policies need to be established to provide the foundation of the programs. Records showing program progress and deficiencies become an important part of program development. Activities to build awareness, educate and enhance prevention need to be done on a regular basis. Support systems need to be established to assist students in their everyday struggles. And finally, for those students who are experiencing problems, an identification, intervention and referral process can help get them back on track. None of this is magic. There are no guarantees. But schools who have implemented SAPs have found that the results are well worth the time and energy. May yours be a success.

STUDENT REFERRAL FORM

If a troubled student is to be helped, specific behavioral data is needed to establish an overview of the problem. It is important that this data be based on behavior which you have actually observed with dates wherever possible. As a rule, isolated instances of poor or unsatisfactory performance are not sufficient grounds for making a referral. It is only when a student exhibits several of the following behaviors, or there is a definite and repeated pattern established that he/she should be referred (exceptions would be cases of immediate life-threatening danger which needed to be handled quickly). Please give this completed form to the student's therapist who will then give it to the Crisis Intervention Team for processing. **ALL INFORMATION SHOULD BE KEPT CONFIDENTIAL.**

STAFF RESPONSE FORM

A referral has been received by the Crisis Intervention Team on one of your students. In order to best help this child, specific behavioral data is needed from as many people as possible. This will help to establish an overview of the problem and highlight any patterns. It is important that this data be based on behavior which you have actually observed, with dates wherever possible. Please complete the attached form as soon as possible and return it to ______________________________ by ___________________. Your help is greatly appreciated.

ALL INFORMATION SHOULD BE KEPT CONFIDENTIAL.

STUDENT REFERRAL FORM

Student: ______________________ **Class:** ____________ **Date:** _______

Referred By: ________________________________

Please check appropriate response and put date where appropriate:

I. Academic Performance Observed:

______ Lower grades, lower achievement

______ Academic failure

______ Falling behind in classwork

______ Incomplete work

______ Declining quality of work

II. Classroom Conduct Observed:

______ Absenteeism

______ In-School absenteeism

______ Tardiness to class

______ Disruptive in class

______ Inattentiveness

______ Lack of Concentration

______ Lack of motivation

______ Sleeping in class

______ Failing memory

______ Extreme negativity

______ Defiance: breaking rules

______ Requires frequent discipline

______ Cheating

______ Fighting in class

______ Throwing objects

______ Defiance of authority

______ Verbal abuse

______ Obscene language, gestures

______ Sudden outburst of temper

______ Vandalism

______ Frequent visits to nurse, counselor, social worker

______ Frequent visits to lavatory

______ Hyperactivity, nervousness

III. Other Unusual Behavior Observed:

______ Erratic behavior

______ Change in peer group

______ Older social group

______ Sudden, unexpected popularity

______ Mood swings

______ Public intimacy; sexual looseness

______ Time disorientation

______ Seeks constant adult attention

______ Unrealistic goals

______ Struggles for perfection

______ Withdrawal

______ Change in personal appearance

______ Change in values, interests

______ Depression

______ Difficulty accepting mistakes

______ Sitting in isolated places

______ Other students express concern

______ Fantasizing, daydreaming

______ Overachievement in grades, activities

______ Rigidly obedient

______ Constantly joking

IV. Possible Alcohol/Drug Behaviors:

______ Staggering or stumbling

______ Odor of alcohol or marijuana

______ Glassy, bloodshot eyes; dark glasses

______ Slurred speech

______ Talks freely about use; bragging

______ Associates with known users

______ Wears alcohol/drug related apparel

______ Possession of alcohol/drugs: Date ____________

______ Possession of drug paraphernalia: Date ____________

______ Selling, delivering: Date ____________

V. Possible Suicide Behaviors:

______Talks about death; suicide

______Giving away possessions

______Writing/drawing is death related

______Has experienced loss (death or divorce)

______Engaging in self-destructive behaviors:
Describe: __________________

______Previous Suicide attempt/ideation

______Depression followed by sudden relief

VI. Possible Gang-related Behaviors:

______Wears gang colors
Describe ______________________

______Wears or displays gang symbols
Describe______________________

______Makes gang signs
Describe______________________

______Associates with known gang members

VII. Other Areas (please specify):

____

____

____

What action have you already taken? (Talked to student, therapist parents, etc.)

What actions do you contemplate taking? What assistance would you like?

VIII. Related Behaviors (to be completed by students counselor/therapist):

______Unexcused absences

______Frequent absenteeism

______Frequent tardiness

______Marked absent but in school

______Frequent disciplinary referrals

______Involvement in thefts, assaults

______Law enforcement problems;
Specify:____

______Home Problems;
Specify:____

______Job problems;
Specify:____

Date Received:_________________________________

Action Taken:

______Information only

______Disciplinary action

______Other (specify):

______Parent conference

______Legal action

RECEIPT OF STUDENT REFERRAL FORM
Confidential

TO:

FROM:

RE: Notification of progress on student referral

DATE:

Thank you very much for your concern regarding ______________________________ and your completed referral form. Your time and effort in the referral of this student is appreciated. The following action has been taken with the student:

______Filed for information; please continue to observe.

______Parent conference held on ________________________.

______Disciplinary action taken:

______Legal action taken:

______Other:

If you notice any changes in behavior (positive or negative), please let me know so that immediate action can be taken.

THANK YOU FOR YOUR HELP!

STUDENT BEHAVIOR UPDATE

Confidential

TO:

FROM:

DATE:

RE: Update on ____

Attached is a copy of the referral form you filled out regarding your concerns about _____________________________________.
One month (____)/two months (____) have elapsed since your original report. Please indicate any observed changes in behavior by placing the following notations opposite the checked items:

I = Improved
S = Same
W = Worse
N - Newly observed

Additional comments are also welcome, especially any positive changes that you may be seeing.

Please give completed form to __________________________ **by** ___/____/____.

THANK YOU FOR YOUR HELP!

TEAM REPORT OF STUDENT REFERRAL

Student Name:________________________________ Date of Birth:_______________

School District:______________________________ Date of Referral:____________

Address:____________________________ Parents Name:________________________

____________________________ Parent Notified: Yes________ No______

Telephone:______________________ Date of Notification:______________________

Grade in School:________________ Time of Notification:______________________

Staff Members Involved:

Observable Behavior (as related on referral forms):

Legal Issues (if any):

Outside Agency Involvement (if any):

Impressions (comments on patterns of behavior, areas of concern, etc.):

Immediate Action Taken:

Results of Parental Contact:

Recommended Plan of Action:

Case to be reviewed at Crisis Intervention Team Meeting on:____________________

Determining Your School's Strengths and Weaknesses Regarding Alcohol and other Drug Abuse Programming & Policies.

Education/
Prevention/
Early

Yes/No

1. Have the school district administrators taken any preventive steps to deal with the problem of alcohol and drug use on campus? Have you implemented these steps at your school site? ______

2. Are the administrators and teachers aware of laws regarding alcohol and drug use on campus? Of laws regarding their rights? Of their responsibility regarding enforcement of and respect for rules, regulations, policies and the law? ______

3. Is inservice training regularly available for teachers regarding alcohol and other drug possession, sale, and use? Regarding required reporting procedures? (Training should be provided at all levels on each school campus.) ______

4. Are programs to promote prevention of alcohol and other drug use a part of school curriculum? ______

5. Are parent-education activities regarding alcohol and other drug prevention provided? Do you promote and encourage attendance at these activities? ______

6. Do school employee job descriptions include alcohol and other drug prevention duties? ______

7. Is inservice training regularly available for teachers and other staff (e.g. bus drivers, food service) regarding signs and symptoms of adolescent chemical alcohol and other drug use as well as patterns of adolescent chemical use? ______

8. Is there a process for early identification of students who may be experiencing alcohol and other drug problems? ______

9. Do you have working relationships with local and community alcohol and other drug abuse service providers? ______

10. Are there procedures for selecting and utilizing local and community alcohol and other drug abuse service providers as resources and/or referral services? ______

11. Is there a process for assisting students who return to school from treatment programs or who may be involved in out-patient programs? ______

12. Are there provisions for on-campus support groups? ______

13. Is there a district-wide policy supporting the implementation and maintenance of prevention and early intervention programming at each school site? ______

Policy/
Discipline

14. Have you developed procedures to deal with students under the influence of alcohol and other drugs or with students selling or possessing drugs? ______

15. Is there a school policy regarding prosecution of students for alcohol and drug violations? ______

16. Are students aware of expectations of school authorities and of school discipline codes in the matter of alcohol and other drug use? ______

17. Are parents made aware of school discipline codes in the matter of alcohol and other drug use? ______

Law
Enforcement

18. Do you have a working relationship with your local law enforcement agency? ______

19. Do you invite local law enforcement agencies to help and advise you on alcohol and other drug abuse? ______

20. Are administrators, teachers, and students urged to cooperate with police? ______

Information Gathering

21. Is statistical information available regarding the scope of the problem of alcohol and other drug abuse at your school and in the community? ______

22. Do you have an alcohol and other drug abuse incident reporting system at your school? ______

23. Is this incident reporting system familiar and available to all school staff members? ______

Security

24. Is security an integral part of the organization of your school? (Security organization should respond to local needs and conditions.) ______

25. Is an on-site staff member designated as responsible for overall school security procedures? ______

26. Do law enforcement or security personnel monitor school facilities during school hours? ______

27. Are hallways, corridors, and other places where students congregate supervised? Are these areas supervised between classes, at lunch, before, and after school? (Teachers and staff should participate in supervision.) ______

28. Are specific persons designated to secure buildings following after-hours activity? ______

29. Is activity at the main entrance to the school open to view? Activity in locker rooms? ______

30. Are parking areas easily monitored and open to view? Are they well-lit in early morning and late evening hours? ______

31. Do students have I.D. Cards or other identification which they are required to carry? ______

32. Is there a visitor procedure? Is it regularly monitored? ______

33. Are signs listing rules and regulations for visitors properly posted? Are unauthorized persons confronted? ______

34. Is there a policy regarding unauthorized visitors or intruders on campus? ______

35. Is there adequate fencing around the school campus? ______

36. Are gates properly secured with working locks? ______

37. Are fences and gates inspected daily? ______

38. Are damaged fences and gates quickly repaired? ______

39. Are local residents encouraged to report suspicious activity to school officials or police? ______

40. If evening and weekend use of school facilities is encouraged, are provisions made for additional supervision? ______

Reprinted from: A Policy Development Manual for Drug Free Schools, V.C. League and Stephanie Soares Pump, Vincente and Associates, California, 1988.

CREATING A SUPPORTIVE ENVIRONMENT FOR PREVENTION

- New way of thinking about old problems
- Helping others learn to adapt and control change
- Optimistic attitude vs. pessimistic approach
- Building support networks
- Being proactive in a reactive world
- Achieving a balance in human service resources
- Developing programs that affect an environment

SETTING THE STAGE FOR PREVENTION

1. Start small and build upon success.
2. Practice communicating ideas about prevention with sympathetic people.
3. Do a lot of personal emissary work.
4. Listen to people's reactions and learn from them.
5. Ask the right questions.
6. Do not rush the process, but build systematically.
7. Keep your expectations at a modest level and you are less likely to be disappointed.
8. Maintain a vision/mission.

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A FENCE--OR AN AMBULANCE?

By Joseph Malins

TWAS A DANGEROUS cliff, as they freely confessed
Though to walk near its crest was so pleasant;
But over its terrible edge there had slipped
A duke and full many a peasant.
So the people said something would have to be done,
But their projects did not at all tally;
Some said, "Put a fence around the edge of the cliff,"
Some, "An ambulance down in the valley."

But the cry for the ambulance carried the day,
For it spread through the neighboring city;
A fence may be useful or not, it is true,
But each heart became brimful of pity
For those who slipped over that dangerous cliff;
And the dwellers in highway and alley
Gave pounds or gave pence, not to put up a fence,
But an ambulance down in the valley.

"For the cliff is all right, if you're careful," they said,
"And, if folks even slip and are dropping,
It isn't the slipping that hurts them so much,
As the shock down below when they're stopping."
So day after day, as these mishaps occurred,
Quick forth would these rescuers sally
To pick up the victims who fell off the cliff,
With their ambulance down in the valley.

Then an old sage remarked: "It's a marvel to me
That people give far more attention
To Repairing results than to stopping the cause,
When they'd much better aim at prevention.
Let us stop at its source all this mischief," cried he,
"Come, neighbors and friends, let us rally;
If the cliff we will fence we might almost dispense
With the ambulance down in the valley.

"Oh, He's a fanatic," the others rejoined,
"Dispense with the ambulance? Never!
He'd dispense with all charities, too, if he could;
No! No! We'll support them forever.
Aren't we picking up folks just as fast as they fall?
And shall this man dictate to us? Shall he?
Why should people of sense stop to put up a fence,
While the ambulance works in the valley?"

But a sensible few, who are practical too,
Will not bear with such nonsense much longer;
They believe that prevention is better than cure,
And their party will soon be the stronger.
Encourage them then, with your purse, voice and pen
And while other philanthropists dally,
They will scorn all pretense and put up a stout fence
On the cliff that hangs over the valley.

Better guide well the young than reclaim them when old,
For the voice of true wisdom is calling,
"To rescue the fallen is good, but 'tis best
To prevent other people from falling."
Better close up the source of temptation and crime
Than deliver from dungeon or galley;
Better put a strong fence 'round the top of the cliff
Than an ambulance down in the valley.

This selection appeared in "The Best Loved Poems of the American People," selected by Hazel Felleman, published in 1936 by the Garden City Publishing Co., Garden City, New Jersey. It remains one of the most unique methods of telling the public health message.

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COMMUNICATION

If you think communication is all talk,
You haven't been listening.
-Ashleigh Brilliant-

Communication is a major factor in education. How we communicate and how effective that process is has a tremendous impact on our ability to function in our positions. However, communication is an extremely complex process and one that is often not part of the process of preparing to be a teacher. When we deal with high risk students, communication is even more crucial to our interactions. We need to work both on our own communication skills as well as being able to help kids learn to communicate more effectively. The following material will attempt to clarify the crucial parts of communication and provide some ideas for creating a more effective communication process.

Logically, communication is a process which occurs between two or more people. In each phase of the process there is a sender and a receiver. Stage one of communication begins in the mind of the sender who formulates the message they want to send. This message then goes to their mouth. Often between brain and mouth something goes wrong and what comes out was not what was thought. Sometimes what goes wrong has to do with a strong emotion (such as anger). Other times it may have more to do with our perception of the world, ourselves or the other person. Regardless, the statement that comes out and becomes speech is different from what was intended. We may or may not be aware of the discrepancy as we still have the original message in our brain. This distorts what we hear in our spoken words. The second stage in communication occurs when the message is heard by the receiver. It goes into the ear and is processed by the brain. Unfortunately, it is processed using the receiver's frame of reference which may be very different from the sender's. Therefore, what is heard may bear little resemblance to the message formulated by the sender.

Anyone who remembers the childhood game of "Telephone" will remember just how distorted this process can get as messages are whispered around a circle and the end result bears little, if any, resemblance to the initial statement.

As an added complication, communication is not just words (unless it is written communication). There are many other parts to the process that play an even larger role in how the message is sent and received. These factors include the tone of voice used, body language, positioning, facial expressions, touch and eye contact. Although many people think that the bulk of most messages is carried by the words, most of the research on communication has indicated something quite different. In fact, only 7% of the message is transmitted by words. The tone of voice carries another 38%

and appearance (which includes body language, positioning, facial expressions, touch and eye contact) carries the other 55%. The most dramatic example of these percentages comes when the verbal message is not congruent with the nonverbal. If someone says "I'm not angry" while they clench their jaw, close their fists and raise their voice, which message do you tend to believe? As educators, then, we need to pay closer attention to the nonverbal than to the verbal when we communicate (both in sending and receiving).

When we communicate with people from a different generation, culture, or area of the country, another factor exists that can interfere with effective communication. This has to do with connotations and colloquial uses of various words. Often, one word will have many different meanings depending on an individual's background and age. In addition, slang terms get developed which may or may not even be actual words. Remember the confusion that was created in the 60's as young people started talking about things being "cool" and "groovy"? Now these same things are "radical" or "rad". Even something as seemingly simple as a carbonated beverage can be referred to as soda, pop, soda pop, tonic or coke (as a generic term) depending on the part of the country in which you reside. Is it any wonder we are plagued by mis-communication?

In order to develop a more effective communication process we must look at several issues. These are:

1) The things that can create barriers to communication (aside from the ones already discussed which are inherent in the process).
2) The tools we can use to improve the receiving of messages.
3) The tools we can use to improve the sending of messages.

Throughout all of this is the underlying assumption that communication takes energy, focus and commitment. We have to be conscious and present in order to communicate fully with another human being. This means putting down or turning off anything that can distract us and focusing our attention solely on the communication that is taking place. Just doing this will clear up a lot of problems.

Barriers to Communication

Although some barriers are built in to the communication process (such as the ones discussed earlier), others are more a function of how we approach the interaction. Some primary barriers to communication with young people in a home, school or community setting are:

- Directing, ordering, commanding
- Moralizing, judging
- Probing, questioning
- Storytelling
- Kidding, teasing

Each of these will be discussed in more detail.

Although kids are generally used to being directed, ordered and commanded, it does not mean that this is an effective communication style. As a matter of fact, they are so used to it that they are very good at tuning it out. They sense the finger being pointed at them as they are told to do something and they "go away" emotionally. They may even agree to do whatever they are being told to do, but then delay or ignore it, hoping that the adult will forget. Even if they do follow through, this type of communication is very one-sided.

Moralizing and judging is another way of pointing fingers at kids. With this, as with directing, it is important to remember that when you have one finger pointing at another person, there are three more pointing back at you. When we tell kids what they should and shouldn't do, feel or believe, we are discounting their actions, feelings and beliefs. Although they do need to be held accountable, particularly for their actions, there are more effective ways to do this that will be discussed later under confrontation and feedback.

Probing and questioning is sometimes necessary, but when it is done in the style of an inquisition, the answers you will get will be less than satisfactory:

Adult	Child
"How was school?"	"Fine"
"What did you do?"	"Nothing"
"Where did you go?"	"Nowhere"
"Who were you with?"	"Some people"
"Why did/didn't you do that?"	"Dunno"

Most of us have had conversations like this that lead nowhere and get more and more like an inquisition as our frustration level rises. Again, a more effective method will be discussed later.

Storytelling is one that kids tend to hate the most. It usually begins with "When I was your age..." or "If I were you..." and results in immediate tuning out by the child. This form of communication often becomes moralizing and judging and, if nothing else, is generally very one-sided. Communication needs to engage both people.

Finally, although there are times when kidding and teasing is very appropriate and is a sign of affection, it needs to be applied with care. First and foremost, make sure that there is a relationship that is solid enough to withstand teasing. Otherwise it may come across as a put-down when this was not the intention. Since educators are usually seen as authority figures to a certain extent, this type of relationship rarely exists. The other danger comes when the teasing takes the form of a "peer" interaction. Kids don't need (or want) adults to be their "buddy". They have plenty of those. Therefore, teasing them in a way that their "buddies" would is not appropriate and tends to be seen as false or contrived.

Tools For More Effective Communication

Just as the barriers mentioned will prevent effective communication from taking place, there are other things which can enhance the process. They are:

- Attending
- Paraphrasing/clarifying
- Reflection of feelings
- Summarization
- Self-disclosure
- Probing (in a positive way)
- Interpretation
- Confrontation or feedback

The first four tend to let the individual know you are listening, clear up any mis-communication and solicit further information. In this way, they are tools for improving our ability to receive messages. The latter four are action skills and tend to be used more to direct the communication, share information, and send messages. Again, each one will be examined separately.

Attending behaviors include all of the nonverbal cues that indicate to the kid that you are listening. Examples might be leaning forward, looking at them, smiling (if appropriate), nodding your head, and using semi-verbal prompts such as "Uh Huh", "And...?" or "I see." All of these encourage the young person to continue talking and to share more information than they would if we did not attend. The majority of kids say that one of the main things they want from adults is to be listened to and taken seriously. Attending behaviors let the child know that this is happening and are a very powerful communication tool. Remember, these behaviors comprise 55% of all communication so you are not just listening, you are sending a message that says "You are important and I want to hear what you have to say."

Paraphrasing or clarifying is an important tool to use to counteract the tendency to misunderstand a message (either because of the difference in meanings given to words or the fact that we interpret messages based on our own frame of reference). We need to be careful with this skill, however. Several years ago a program came out called "active listening" based on the counseling techniques of Carl Rogers. People learned to say "What I hear you saying is..." The problem was that people used this phrase indiscriminately and kids got tired of hearing it. The reason for paraphrasing or clarifying is to clear up any misunderstandings. It does not need to be used after every statement, and it can be phrased in different ways. We can phrase it as a question "Do you mean...?" or a statement that allows the person to let us know if we have heard them correctly. Either way, we need to put what we heard into our own words rather than parrot what the person has said. And remember to use this tool sparingly and wisely so that you don't come across to the child as a "shrink" or an "active listening robot".

Another powerful tool for letting someone know that you are listening and for soliciting further information is reflection of feelings. This is another tricky one also. Generally we have been taught to do this wrong. We tend to think of reflection of feelings as being a statement such as "You must be really angry" or "You seem hurt". This is really making assumptions and/or judgements since I can't really know how anyone else feels unless they tell me. Statements such as these are particularly dangerous with kids who tend to respond: "How can you know how I feel". A more effective, and honest, way of doing reflecting feelings is to share our own feelings about what the person has said. This would involve a statement such as: "When you said _____ I felt _____." This can then turn into a dialogue as the person says "That's exactly how I feel" or "For me it's not so much feeling _____ as it is _____." With kids, in particular, the fact that someone has responded to them on a feeling level encourages them to share feelings in return. It can also help them to place a name on a feeling, which is often difficult. Remember, that what we are doing here is sharing on a heart level with a child, not dumping our problems on them. If done with this in mind, reflection of feelings can be one of the most important tools in working with high risk students.

The final listening and encouraging behavior is summarization. This is generally used if some kind of agreement has been reached. As with paraphrasing it involves putting the agreement in your own words to check the accurateness with the kid. Then any final negotiations ("I never agreed to do that!") can be done before the communication is over.

The rest of the effective communication tools also attempt to let the person know that you are actively engaged in the communication process and to gather information, but they do so more actively. With these, we can guide the communication more and learn what we need in order to better understand the child. We can also use these tools to share our own perceptions and/or set boundaries for behavior by sending very clear messages.

The first of the action behaviors is self-disclosure. On the most basic level this involves telling people things about myself that they didn't previously know. This can be as simple as telling them my name and where I live or as complex as relating my dreams and secrets. Regardless of the information, the most effective self-disclosure is done purposely and consciously. It needs to be tied to the topic at hand rather than going off on a tangent. It is most powerful when it is tied to a feeling, as in: "I've felt that way at times, also. For instance..." It is important here to avoid storytelling. Just give a brief example of a time when something similar happened and then allow the other person to elaborate more. This serves two purposes. One, I now have an emotional investment to the communication process. When both parties share something personal, it is a more equal process and, consequently, more comfortable for the person who initiated the sharing. Two, if I have misinterpreted what the person was saying, my response will indicate that. They can then say "I think that's different than what I was talking about. What I meant was ..." Either way, through self-disclosure, without storytelling, I can encourage further communication and information. Many times we hesitate to share anything personal with students because it doesn't seem "professional". And yet, if we share personal information without dumping or dominating the conversation, it can lead to trust and a relationship that allows the child to share more of themselves.

The second action behavior under communication is one that was also mentioned as a roadblock -- probing. There are times when you will need to get information in a more direct way. The way this is done can have a bearing on the amount and type of information received. Asking questions that refrain from any value judgement or criticism will tend to get you a more positive response. Asking open ended questions rather than ones that can be answered with one or two words is also useful. And finally, staying away from questions that begin with "Why" as these almost always carry a judgmental tone even if that was not intended.

Interpretation is the next action and needs to be used very cautiously and sparingly. Interpretation is most often used in conjunction with confrontation, which will be discussed next. The most powerful type of interpretation with kids is to use the discrepancy between what they say and what they do as a way of pointing out what you see. For example: "You say that you want to go to a good college and have even signed up to take the ACT, and yet in class your grade has dropped to a C and you are missing two out of the last four assignments. I'm confused about this since your behavior does not seem to fit your words". This not only allows the student to see what they are doing, it also provides a starting place for coming to some agreement over changes in behavior. By doing it in a way that expressed concern you also open a possible door for the child to begin talking about what is happening to cause the discrepancy.

This leads into confrontation which is the last of the four action behaviors. This was discussed in more detail in the section on intervention so will be mentioned only briefly. Confrontation or feedback does not involve yelling, blaming or accusing. It is more like holding up a mirror to the person and saying: "This is what I see that concerns me."

The key to confrontation is to use "I" messages as much as possible and to keep it short and simple. There are three basic parts to a confrontation:

I saw (describe the behavior)

I feel/felt (expression of concern or other appropriate emotion)

I did/will do (consequences of the behavior)

These can be said in different ways so that you don't sound like a robot, but each is important to an effective confrontation.

Obviously, as you look through the eight skills that enhance communication, they will each be used in different circumstances. Becoming familiar with each of them and practicing them will help in the communication you have with the kids around you as well as with your co-workers, family and friends. Since communication is such an integral part of our lives, it behooves us all to learn the art and skill of communicating.

ALL I EVER REALLY NEEDED TO KNOW I LEARNED IN KINDERGARTEN

By Robert Fulghum

Reprinted from Kansas City Times, Sept. 17, 1986

Most of what I really need to know about how to live, and what to do, and how to be, I learned in kindergarten. Wisdom was not at the top of the graduate school mountain, but there in the sandbox at nursery school.

These are the things I learned: Share everything. Play fair. Don't hit people. Put things back where you found them. Clean up your own mess. Don't take things that aren't yours. Say you're sorry when you hurt somebody. Wash your hands before you eat. Flush. Warm cookies and cold milk are good for you. Live a balanced life. Learn some and think some and draw and paint and sing and dance and play and work every day some.

Goldfish and hamsters and white mice and even the little seed in the plastic cup--they all die. So do we.

And then remember the book about Dick and Jane and the first word you learned, the biggest word of all: LOOK. Everything you need to know is in there somewhere. The Golden Rule and love and basic sanitation. Ecology and politics and sane living.

Think of what a better world it would be if we all--the whole world--had cookies and milk about 3 o'clock every afternoon and then lay down with our blankets for a nap. Or if we had a basic policy in our nation and other nations to always put things back where we found them and cleaned up our own messes. And it is still true, no matter how old you are, when you go out into the world, it is best to hold hands and stick together.

RESILIENCY IN HIGH RISK KIDS

Don't be afraid to give some of yourself away...
It will all grow back.
-Ashleigh Brilliant-

The identification of risk factors and causes of a particular disease can be very beneficial in identifying those people who are most at risk. Ideally, once these individuals have been identified, they can make some changes in their lives to prevent the disease from occurring, or at least reduce their chances. The person who is an overweight smoker with high blood pressure and who drinks on a regular basis is a high risk for heart disease. However, by losing weight, stopping smoking and cutting down on or quitting drinking, they can substantially reduce their risk. Obviously this is easier said than done, but we know that there are things that can be done to lower the risk of contracting certain diseases.

The same is true when discussing high risk behaviors such as substance abuse, suicide, eating disorders, delinquency, or others. Many of the risk factors have already been discussed. The unfortunate thing with the factors leading to high risk behaviors is that often they are not under the control of the individual. A child cannot control their family environment (divorce, parental drinking, abuse) or the community around them (economic deprivation, extreme mobility, availability of drugs). They have no power over school policies and only a small amount over the peer culture that condones drug use. Although most kids have some control over their success in school, a child with a learning disability has difficulty with even this (seemingly) easy task. Some of the risk factors such as alienation and rebelliousness or antisocial behavior can be said to be under the child's control, but in reality many of these behaviors are a by-product of the family dysfunction or community problems about which they can do nothing.

If this is the case, is it hopeless? Is there a way to lower the risk for these kids or are they doomed to develop high risk behaviors? The reality is that there is something that can be done, but it isn't necessarily easy. This will be especially true of special education students who start out with several strikes against them already.

For years, most of the research about high risk kids focused on disease, pathology, and maladaption and were retrospective in design. After an individual had developed a problem, the researchers would look back and try to identify the particular factors that led up to the current behavior or disease. Although this was better than nothing, it was extremely limited from the standpoint of prevention. More recently, some pioneering researchers have been focusing their research not on kids who develop problems, but on kids who despite all of the risk factors in their lives are able to avoid high risk behaviors. These kids are known as "resilient" and researchers have been attempting to identify the "protective factors" that allow them to cope and develop into healthy adults in the face of severe stress and "at-riskness".

Since many of the risk factors are imposed on kids from the outside (families, communities, schools, and peer groups) many of the protective factors need to be built from the outside. The development of these protective factors is one of the primary roles of prevention programs and should be thoughtfully and consistently integrated into any Student Assistance Program. Given the fact that special education students tend to be at higher risk, it is especially important to focus on building protective factors in these kids.

Many of the most commonly identified protective factors have to do with social competencies. These help the child be less vulnerable in stressful situations. Examples are:

1) **Effectiveness in work, play, and relationships:** The child is able to identify goals, establish realistic steps to reach that goal, and follow through on these steps. They are also able to establish healthy, supportive friendships.
2) **Healthy expectancies and a positive outlook:** The child is oriented toward success and holds a belief that their effort and initiative will allow them to reach their goal.
3) **Self-esteem and internal locus of control:** This is, perhaps, one of the most important factors since it is the foundation of all the others. The child believes that he/she has some control over the future rather than viewing themselves as a helpless victim. They feel competent, important, and loveable.
4) **Self-discipline:** The child has a future orientation and is able to delay gratification.
5) **Problem-solving and critical thinking skills:** They are able to be reflective, to think abstractly and to be flexible in their approaches to problem-solving. They are able to identify several alternatives to solving a particular problem and outline the possible consequences of each choice.
6) **Humor:** The child can laugh at him/herself and the situations around them. They can generate comic relief and find alternative amusing ways of looking at things.

All of these factors will help the child deal with the stress and the risk factors that surround them.

Building these protective factors, especially in special education students, is not easy. The foundation will be to foster positive self-esteem which will be discussed next. A second key strategy that has been identified by every resiliency researcher is the development of positive, supportive relationships between the high risk child and a healthy adult role model. Teachers frequently act as role models and can be an important protective factor in these students' lives. Other strategies have been developed by David Hawkins who recommends a social development approach including:

- Promoting bonding to family, school and positive peer groups through opportunities for active participation.
- Defining a clear set of norms against use.
- Teaching the skills needed to live the norms and opportunities.
- Providing recognition, rewards and reinforcement for newly learned skills and behaviors.

(From: Not Schools Alone, California Department of Education, 1990)

The personal and pro-social skills referred to by Hawkins as being necessary to "live the norms and opportunities" include five primary categories. The first are social skills such as listening, communication (both with peers and with adults), and the ability to participate in groups. Another skill that is crucial for building resiliency is the ability to deal with feelings. This includes being able to identify and verbalize one's own feelings, develop empathy for another person's feelings, and be able to negotiate differences. The third pro-social skill involves aggression. The resilient child needs to be able to be appropriately assertive, cooperate with others, and develop alternatives to fighting. Fourth is the ability to deal with stress. This would include handling peer pressure, criticism and failure as well as being able to deal with conflicting messages. Finally, resilient children need to be able to develop healthy planning skills. This includes the ability to define problems accurately, set goals and make decisions, be organized, and follow through on decisions.

All of these protective factors (relationships with adults, pro-social skills, self-discipline, and a positive outlook) depend on the foundation of self-esteem. Without a positive view of myself it will be difficult to develop the others. Although it is true that as I practice and learn the pro-social skills and develop healthy relationships with adults, I will increase my self-esteem, it is also true that there must be a base for believing I am worthwhile before I will be motivated to develop positive behaviors. For this reason, self-esteem will be discussed in more detail along with strategies for building positive self-esteem in the classroom.

UNDERSTANDING & BUILDING SELF-ESTEEM

The concept of self-esteem, is a difficult one to define. However, it has been listed as one of the primary protective factors in moving high-risk students toward resiliency. Because of this, it is important in establishing an effective prevention program to describe what it is, how it forms, and what teachers can do to encourage its positive development.

The first thing that is obvious is that everyone has self-esteem. The key to resiliency is developing positive self-esteem. We can define self-esteem or self-concept as the accumulation of all the beliefs, attitudes and opinions a person holds as true about him/herself. It includes all of the internal statements that a person makes about themselves. These thoughts or images of one's self may come from comments from others or from one's own imagination. They may be positive or negative, accurate or inaccurate. Nevertheless, they are what a person believes to be true and real.

It is these thoughts or beliefs about one's self that determines behavior.

> "A person's judgement of himself influences the kinds of friends he chooses, how he gets along with others, the kind of person he marries, and how productive he will be. It affects his creativity, integrity, stability, and even whether he will be a leader or a follower. His feelings of self-worth form the core of his personality and determines the use he makes of his aptitudes and abilities. His attitude toward himself has a direct bearing on how he lives all parts of his life. In fact, self-esteem is the mainspring that slates every child for success or failure as a human being."
>
> -Dorothy Briggs,
>
> Your Child's Self-Esteem -

How a child feels about him/herself will effect their susceptibility to social/peer influences. For example, researchers have found that adolescents with low self-esteem have a greater tendency to engage in premarital sexual relationships and are more likely to be responsible for teen pregnancies. Self-concept has also been linked closely to drug use and abuse in the sense that individuals with low self-esteem are more likely to get involved in drug use at earlier ages and experience more problematic use.

Self-concept begins to form at a very early age. Experiences with "significant others" precondition the development of self-concept. Parents are the most powerful individuals to shape a child's self-concept because of the amount of time they spend with him/her and the child's total dependency on them. It is parental warmth and respectful treatment that enables a child to develop a positive sense of self. Unfortunately, for many children this warmth and respectful treatment do not occur. Children who grow up in families where there is dysfunction of some kind (addiction, abuse, mental illness, etc.) form a very different sense of self.

Whatever develops, positive or negative, by the time a child enters school, he/she has usually collected a vast store of reflections and information from which comes the first over-all estimate of his/her worth. The child's reactions to learning and to the physical, social, and emotional climate of the classroom will be related to the beliefs and attitudes he/she has about him/herself. At this point in time teachers, can have an impact on the continued collection of data about one's self.

In determining whether a child has developed or is developing a positive or negative sense of self, we can look for several characteristics. These characteristics include thought processes as well as behaviors. In defining them, we begin to further define self-concept or self-esteem.

There are four thought processes that develop when a person has a positive self-concept. The first is "I can handle it". This is not in the sense of I can handle everything all by myself without help, but more an ability to plan and carry out those plans effectively. It includes the knowledge that with the right tools or the right assistance I can deal with most of the things that come with life. The second thought process is one called "downward comparison". Although this sounds negative, it is a view on life which involves the knowledge that no matter how bad things get, there are always people worse off and there are things I can be grateful for. On the other hand, this does not mean becoming a "Pollyanna" and saying that everything is perfect when it is not. The third thought process involves "restructuring". This process is one of taking negatives and reframing them. Seeing a "problem" as a "challenge" or a "learning process" is an example of this. Finally, a person with positive self-esteem tells themselves "I'm in control". This is similar to the first thought but is more about being able to control how I respond to the world and to events rather than being about competencies.

Along with the thought processes that come from positive self-esteem, there are nine behaviors that generally exist. They are as follows:

1) Ability to problem solve.
2) Ability to forecast and plan ahead.
3) Ability to take action (even if the action doesn't always work or isn't always appropriate - at least they do something).
4) Asking for help (this is a major indicator).
5) Ability to be compassionate and recognize other peoples' feelings.
6) Ability to be assertive rather than aggressive or passive.
7) Ability to withdraw from a negative situation or to say "no".
8) A sense of humor.
9) A belief that they are safe and the ability to function as if they are (but not to the point of taking unnecessary risks).

The more a child displays these behaviors in all areas (or most areas) of their lives, the more we can say they have developed a positive sense of self. It leads to the ability to live by four statements:

1) I am competent.
2) I am safe.
3) I can handle whatever I get dealt.
4) I can take problems and see them as challenges.

And by way of a cycle, the more I act as if I believe these things, the better I feel about myself.

In order to build positive self-esteem in children there are three primary things that need to be increased. First, is the need to build attachments to other human beings (particularly older ones). It doesn't really matter whether these people are related to the child or not, although the closer the connection, the more influential it will be. The second area is to increase their resources. This happens in two ways. The first is by providing them with meaningful activity. Children need to feel important and in order to feel this, they must be allowed to contribute at home or at school. They also need positive role models; people they can look to and learn how to be healthy. Unfortunately, for children as well as adults, these people are getting harder and harder to find. The third area that needs to be increased is the child's coping skills. This ties back into the lists of how they think and how they behave. As their abilities to plan and act and be assertive are increased, their overall self-worth goes up accordingly.

While it would be nice if all of the required building blocks for self-esteem were provided at home, the reality is that many children enter school with the beginnings of a very negative self-concept. At this point the teacher becomes a significant person in the child's life and occupies a position similar to that which parents assume in the home. The teacher is the central figure in countless situations which can help the child accept him/herself. Even the child without home support has a chance to see him/herself differently at school if he/she is treated with warmth and respect and has success in at least some school tasks. Bear in mind, however, that change in self-concept usually takes place slowly and with sustained, consistent effort.

The following are some specific methods for helping students to build positive self-concepts:

1. Teach well! The most important thing a teacher can do to improve poor self-image is to teach effectively. A student who is failing to learn won't feel good about himself no matter what else is done. Good, careful instruction makes learning easier and leads the student to success. There is nothing more important for any student than believing and experiencing that he is able to learn. When in doubt about what to do to improve self-concept, teach!
2. Help students to find some area that has challenge for them and in which they find success. Self-confidence is very much the result of having met a series of challenging situations. This does not mean that students must never experience failure. It just means helping students find areas where they can feel successful.
3. Relate student successes to a more central belief, such as general academic ability. Society puts very heavy emphasis on academic ability. If a student can see him/herself as capable of learning, they begin to develop a central belief. Isolated successes can be related to central beliefs, by complimenting a student on learning ability as well as on the finished product. For example, if a student produces a good piece of art work, the statement can be made; "I really like your picture, John. I noticed you learned to use the charcoal quickly." This relates the student's artistic talent to what may be a more central belief about himself--the ability to learn.

4. Demonstrate caring and acceptance for students. This is important because a student must see that he has worth as an individual. The best way to demonstrate care and acceptance is to show an honest interest in the student. By far, the most important way to show interest is by listening. But be forewarned! Listening well is an exercise in keeping attention focused and, by necessity, hard work.
5. Use special notes, awards and certificates to make students feel special. There are few self-concept building strategies more potent than that of taking time after school to write a note to a student telling him that a particular good behavior was noticed, he did something well or that he is liked as a person. Tape the note to the student's desk and secretly watch his expression as he discovers it the next morning.
6. Give students some responsibility. The student with a poor self-concept is often surprised and pleased when someone thinks he can handle responsibility. Give the student responsibility as reinforcement for a particularly fine effort or for no special reason at all. This can be very effective in building a student's self-concept, for it demonstrates a level of trust in the student's ability to handle himself in a mature way.
7. Teach students to stop engaging in self-depreciation and start engaging in self-appreciation. Self-depreciation tends to reinforce a student's low estimation of his self-worth. On the other hand, teaching students to talk positively of themselves will go a long way toward improving their self-concept.

8. Teach students to use the phenomenon of inner speech in such a way that they build their own self-esteem. Many students have developed habits of negatively evaluating themselves by using their inner speech to criticize themselves. They can be taught to reverse this process and begin to believe in their intrinsic worth.
9. Teach students that it is acceptable to make mistakes and to try again after mistakes and failures. Mistakes can cause severe self-image problems. Failures can cause students to "give up" and quit trying altogether. Students can be taught to deal with mistakes and failures in a manner which precludes them from becoming embarrassed or discouraged.
10. Teach students how not to allow put-downs and criticisms to erode their self-esteem. Students can learn how to lessen the amount of criticism they receive from others and how to use their imagination and inner speech to keep any put-downs they do receive from "sinking in" and hurting them.
11. Teach students to nurture and support one another by increasing positive interactions. Some groups blend together as a supportive community--a hardworking, kin, and cooperative body. Other groups are nonsupportive and antagonistic and students tend to be hostile to one another.
12. Teach students to visualize themselves as self-confident and successful in the things that are important to them and to affirm to themselves that these images represent plausible goals. Students who develop habits of positive imagery and affirmation are able to guide themselves through difficult tasks or fearful events.

13. Create an environment in the classroom where students learn to accept and express their feelings openly without fear of criticism or rejection. Allowing a student to "own" his personal feelings and reactions has a strong impact on his self-esteem. It permits him to say, "It's all right to be me. My inner experiences are legitimate even when they differ from others. Having certain feelings at certain times in no way detracts from my value as a person."
14. Help parents to become aware of the tremendous influence they have on their child's self-concept. When parents, themselves, change their conception of their child and begin to see their child differently; when they raise their expectations and their interest, their child will begin to behave in a manner consistent with the parental conception. Take the opportunity at parent conferences to make parents aware of the direct relationship of self-concept to achievement and also of their own importance in the development of their child's self-concept. Explain that their child desperately needs their recognition. This is expressed cogently by the boy who said, "Mother, let's play darts. I'll throw the darts and you say, 'Wonderful'."
15. Model: The best way to teach students to feel good about themselves is to provide a positive model. Accept yourself at all times.

Although there are no guarantees, the more we can build positive self-esteem in children early and continue to foster it, the better protected they will be from high risk behavior. And, bear in mind always, that in order for us to build positive self-esteem in students, we must possess it ourselves. One of the best things you can do for kids is to take care of yourselves and allow them to see you do so. Then we can build a "self-esteem promoting" school environment which nurtures mutual respect, value and uniqueness; encourages personal power and responsibility; and positive life goals. In this type of environment, all students (even those with difficulties learning) can achieve and experience success. They then become prepared to go out into the world and tackle life as it comes, no matter what obstacles may lie ahead.

MASKS: An Epilogue

Don't be fooled by the face I wear, for I wear a thousand masks,
And none of them are me.
Don't be fooled, for God's sake, don't be fooled.

I give you the impression that I'm secure, that confidence is my name and coolness my game,
And that I need no one. But don't believe me.

Beneath dwells the real me in confusion, in aloneness, in fear.
That's why I create a mask to hide behind, to shield me from the glance
That knows, but such a glance is precisely my salvation.

That is, if it's followed by acceptance, if it's followed by love.
It's the only thing that can liberate me from my own self-built prison walls.
I'm afraid that deep down I'm nothing and that I'm just no good,
And that you will see this and reject me.

And so begins the parade of masks. I idly chatter to you.
I tell you everything that's really nothing, and
Nothing of what's everything, of what's crying within me.

Please listen carefully and try to hear what I'm Not saying.
I'd really like to be genuine and spontaneous, and ME.
But you've got to help me. You've got to hold out your hand.

Each time you're kind and gentle, and encouraging,
Each time you try to understand because you really care,
My heart begins to grow wings, very feeble wings, but wings.

With your sensitivity and sympathy, and your power of understanding,
You alone can release me from my shallow world of uncertainty.
It will not be easy for you. The nearer you approach me,
The blinder I may strike back.
But I'm told that Love is stronger than strong walls,
And in this lies my hope, my only hope.

Please try to beat down these walls with firm hands,
But gentle hands, for a child is very sensitive.

Who am I, you may wonder,
I am every man you meet, and also every woman that you meet,
And I am YOU, also.

Author Unknown

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TWELVE STEP PROGRAMS

> We all wear masks, and the time comes
> when we cannot remove them
> without removing some of our own skin.
> -Andre Berthiaume

Recovery from chemical dependency for the addict and the family is a very difficult proposition. The denial process has become so entrenched and the enabling so second nature that for most people it takes the help of others. Some of the most successful programs for long term recovery are the Twelve Step Programs of Alcoholics Anonymous (A.A.), Narcotics Anonymous (N.A.), and Alanon and Alateen. Their beliefs, structure, and foundation of mutual support allow people to recover who might otherwise continue in their pain and suffering until death.

Alcoholics Anonymous was the result of two men (Bill W. and Dr. Bob) who found that by helping other people stay sober, they could stay sober themselves. This was in 1935 and since that time A.A. has grown to the point where there are over 1.5 million members in virtually every corner of the globe. From this success came Alanon which uses the same concepts to help spouses and other family members of alcoholics in their struggle to stop enabling. In July 1953 the first Narcotics Anonymous meeting was held in Southern California, also drawing from the success and structure of A.A. There are now over 1 million members of N.A. Nar-Anon has followed for family members as well as Alateen and Alatot for children of alcoholics. Other dysfunctions have since been helped through the use of the Twelve Step philosophy. Programs such as Overeaters Anonymous, Gamblers Anonymous, Emotions Anonymous, and Sex Addicts Anonymous. Most recently, Smokers Anonymous is attempting to help people trying to "kick the nicotine habit".

The following is from a document that was published by Alcoholics Anonymous in 1953. It describes the A.A. program and it's basic tenets. The Twelve Steps and Twelve Traditions are then listed. Each of the aforementioned spin-offs of A.A. has used the same structure with very slight modifications made to the language to accommodate other addictions or problems.

THIS IS ALCOHOLICS ANONYMOUS

Alcoholics Anonymous (A.A.) is a fellowship of men and women who share their experience, strength, and hope with each other that they may solve their common problem and help others to recover from alcoholism.

* The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions.

* A.A. is not allied with any sect, denomination, politics, organization, or institution; does not wish to engage in any controversy; neither endorses nor opposes any causes.

* Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

Who We Are

We in A.A. are men and women who have discovered and admitted that we cannot control alcohol. We have learned that we must live without it if we are to avoid disaster for ourselves and those close to us.

With local groups in thousands of communities, we are part of an informal international fellowship with members in more than ninety countries. We have but one primary purpose; to stay sober ourselves and to help others who may turn to us for help in achieving sobriety.

We are not reformers and we are not allied with any group, cause, or religious denomination. We have no wish to dry up the world. We do not recruit new members, but we do welcome them. We do not impose our experience with problem drinking on others, but we do share it when we are asked to do so.

Within our membership may be found men and women of all ages and many different social, economic, and cultural backgrounds. Some of us drank for many years before coming to the realization we could not handle alcohol. Others were fortunate enough to appreciate, early in life or in their drinking careers, that alcohol had become unmanageable.

The consequences of our alcoholic drinking have also varied. A few of us had become derelicts before turning to A.A. for help. Some had lost family, possessions, and self-respect. We had been on skid row in many cities. Some of us had been hospitalized or jailed times without number. We had committed grave offenses--against society, our families, our employers, and ourselves.

Others among us have never been jailed or hospitalized. Nor had we lost jobs or families through drinking. But we finally came to a point where we realized that alcohol was interfering with normal living. When we discovered that we could not live without alcohol, we too sought help through A.A.

All the great faiths are represented in our Fellowship and many religious leaders have encouraged our growth. There are even a few self-proclaimed atheists and agnostics among us. Belief in, or adherence to, a formal creed is not a condition of membership.

We are united by our common problem, alcohol. Meeting and talking and helping other alcoholics together, we are somehow able to stay sober and to lose the compulsion to drink, once a dominant force in our lives.

We do not think we are the only people who have the answer to problem drinking. We know that the A.A. program works for us and we have seen it work for every newcomer, almost without exception, who honestly and sincerely wanted to quit drinking.

Through A.A., we have learned a number of things about alcoholism and about ourselves. We try to keep these facts fresh in our thinking at all times because they seem to be the key to our sobriety. For us, sobriety must always come first.

We Made A Decision

All of us now in A.A. had to make one crucial decision before we felt secure in the new program of life without alcohol. We had to face the facts about ourselves and our drinking realistically and honestly. We had to admit that we were powerless over alcohol. For some of us, this was the toughest proposition we had ever faced.

We did not know too much about alcoholism. We had our own idea about the word alcoholic. We tied it up with the down-and-out derelict. We thought it surely meant weakness of will, weakness of character. Some of us fought off the step of admitting that we were alcoholics. Others only partially admitted it.

Most of us, however, were relieved when it was explained to us that alcoholism was an illness. We saw the common sense of doing something about an illness that threatened to destroy us. We quit trying to deceive others--and ourselves--into thinking that we could handle alcohol when all the facts pointed the other way.

We were told from the beginning that no one could tell us that we were alcoholics. The admission had to come from us--not from a doctor or minister or wife or husband. It has to be based on facts which we knew to be true. Our friends might understand the nature of our problem, but we were the only ones who could tell for sure whether or not our drinking was out of control.

Frequently we asked: "How can I tell if I am really an alcoholic?" We were told that there were no hard and fast rules for determining alcoholism. We learned that there were, however, certain tell-tale symptoms. If we got drunk when we had every reason to stay sober, if our drinking had become progressively worse, if we no longer got as much fun from drinking as we once had--these, we learned, were apt to be symptoms of the illness we call alcoholism. Reviewing our drinking experiences and their consequences, most of us were able to discover additional reasons for recognizing the truth about ourselves.

Quite naturally, the prospect of a life without alcohol seemed a dreary one. We feared that our new friends in A.A. would be dull or, worse, yet, wild-eyed evangelists. We discovered that they were, instead, human beings like ourselves. But with the special virtue of understanding our problem--sympathetically, without sitting in judgement.

We began to wonder what we had to do to stay sober, what membership in A.A. would cost and who ran the organization locally and worldwide. We soon discovered that there are no musts in A.A., that no one is required to follow any formal ritual or pattern of living. We learned also that A.A. has no dues or fees of any kind; expenses of meeting rooms, refreshments, and literature are met by passing the hat. But, even contributions of this kind are not a requirement of membership.

It soon became apparent to us that A.A. has only a minimum of organization and has nobody giving orders. Arrangements for meetings are handled by group officers who move on regularly to make room for new people. This rotation system is very popular in A.A.

Staying Sober

How, then, do we manage to stay sober in such an informal, loosely knit fellowship? This answer is that, once having achieved sobriety, we try to preserve it by observing and following the successful experience of those who have preceded us in A.A. Their experience provides certain tools and guides which we are free to accept or reject, as we may choose. Because our sobriety is the most important thing in our lives today, we think it wise to follow the patterns suggested by those who have already demonstrated that the A.A. recovery program really works.

The Twenty-Four Hour Plan

For example, we take no pledges; we don't say that we will never drink again. Instead, we try to follow what we call the Twenty-Four Hour Plan. We concentrate on keeping sober just the current twenty-four hours. We simply try to get through one day at a time without a drink. If we feel the urge for a drink, we neither yield nor resist. We merely put off taking that particular drink until tomorrow.

We try to keep our thinking honest and realistic where alcohol is concerned. If we are tempted to drink--and the temptation usually fades after the first few months in A.A.--we ask ourselves whether the particular drink we have in mind would be worth all the consequences we have experienced from drinking in the past. We bear in mind that we are perfectly free to get drunk, if we want to, that the choice between drinking and not drinking is entirely up to us. Most important of all, we try to face up to the fact that, no matter how long we may have been dry, we will always be alcoholics--and alcoholics, as far as we know, can never again drink socially or normally.

We follow the experience of the successful oldtimers in another respect. We usually keep coming regularly to meetings of the local A.A. group with which we have become affiliated. There is no rule which makes such attendance compulsory. Nor can we always explain why we seem to get a lift out of hearing the personal stories and interpretations of other members. Most of us feel that attendance at meetings and other informal contacts with fellow A.A.'s are important factors in the maintenance of our sobriety.

Where To Find A.A.

A.A. help is available without charge or obligation. There are groups of us in many cities, villages, and rural areas throughout the world. Many groups are listed in the community telephone directory and information about local meetings may often be obtained from doctors and nurses, from the clergy, newspaper people, police officials, and others who are familiar with our program. In many cities there are alcoholism treatment centers that know about A.A. Those who cannot get in touch with a group in their community are invited to write to the world service office: Alcoholics Anonymous, Box 459, Grand Central Station, New York, NY, 10017. They will put you in touch with the group nearest you. Should you live in a remote area and there is no nearby group, they will tell you how a number of lone members are staying sober by using A.A. principles and the A.A. program.

Anyone Who Turns To A.A. Can Be Assured That His or Her Anonymity Will Be Protected

If you feel that you may have an alcoholic problem and earnestly want to stop drinking, more than 650,000 of us can testify that A.A. is working for us--and that there is no reason in the world why it should not work for you.

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THE TWELVE STEPS

1. We admitted we were powerless over alcohol--that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs.

THE TWELVE TRADITIONS

1. Our common welfare should come first; personal recovery depends on A.A. unity.

2. For our group purpose there is but one ultimate authority--a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.

3. The only requirement for A.A. membership is a desire to stop drinking.

4. Each group should be autonomous except in matters affecting other groups or A.A. as a whole.

5. Each group has but one primary purpose--to carry its message to the alcoholic who still suffers.

6. An A.A. group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.

7. Every A.A. group ought to be fully self-supporting, declining outside contributions.

8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.

9. A.A., as such, ought never by organized; but we may create service boards or committees directly responsible to those they serve.

10. Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never by drawn into public controversy.

11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.

12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

This is just a short synopsis of a very simple but very complex program of recovery. To fully understand A.A. and other Twelve Step programs it is recommended that you read Alcoholics Anonymous and Twelve Steps and Twelve Traditions. These are both books written by the founding members of A.A. explaining the program. Another excellent way to understand the program is to attend some open meetings.

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STUDENT ASSISTANCE PROGRAMS IN SPECIAL EDUCATION

CONFERENCE DAILY EVALUATION

Date: ______________________________

Presenter(s): ______________________________

1) What was your overall evaluation of this conference?

1 2 3 4 5
Poor Excellent

2) How meaningful was the content of this conference?

1 2 3 4 5
Poor Excellent

3) How well was this conference organized?

1 2 3 4 5
Poor Excellent

4) How well did the conference meet your needs?

1 2 3 4 5
Poor Excellent

Comments:

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CONFERENCE DAILY EVALUATION

Date: ______________________________

Presenter(s): ______________________________

1) What was your overall evaluation of this conference?

1	2	3	4	5
Poor				Excellent

2) How meaningful was the content of this conference?

1	2	3	4	5
Poor				Excellent

3) How well was this conference organized?

1	2	3	4	5
Poor				Excellent

4) How well did the conference meet your needs?

1	2	3	4	5
Poor				Excellent

Comments:

NSSEO COMPREHENSIVE SPECIAL EDUCATION DRUG INITIATIVE
Miner LD Center • 1101 East Miner • Arlington Heights, Il 60004
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